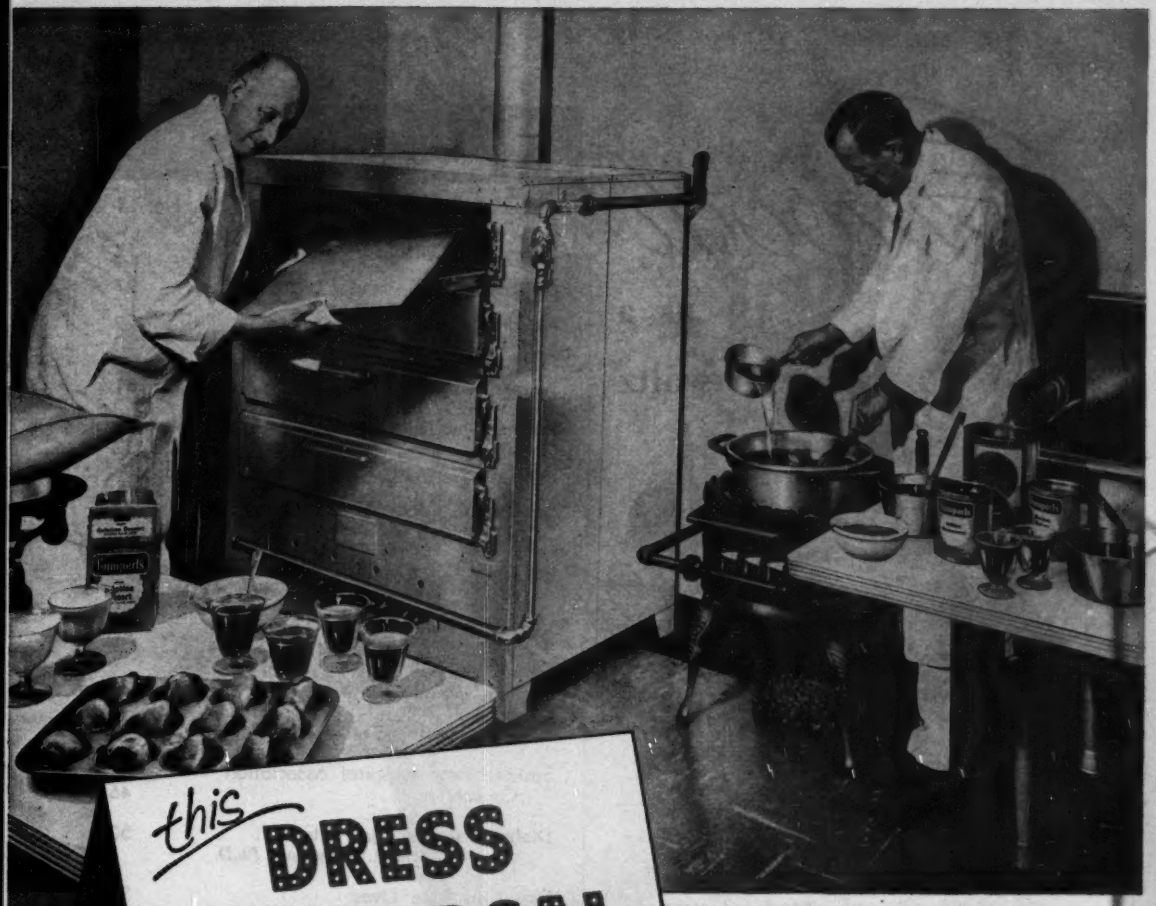
Canadian Hospital

- *Nursing Staff Personnel Policies*
- *The Cobalt Therapy Unit at Saskatoon*
- *Saskatchewan and Alberta Conventions*

November, 1952

Official Journal—Canadian Hospital Council



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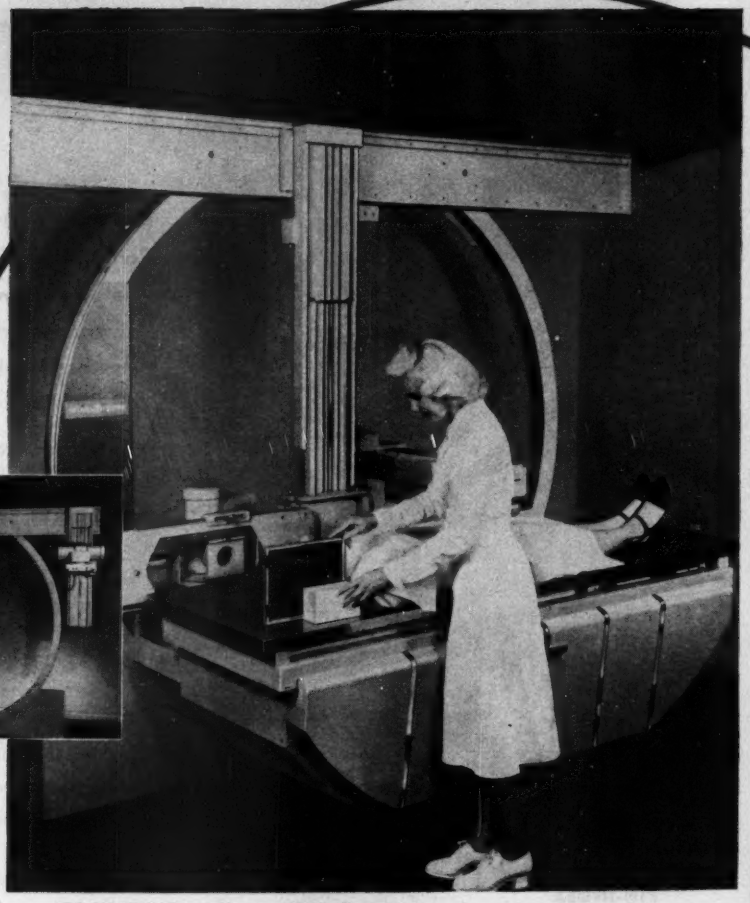

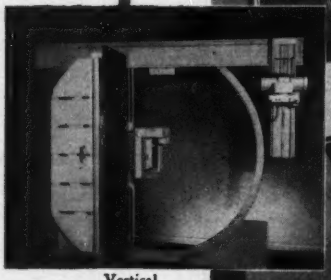

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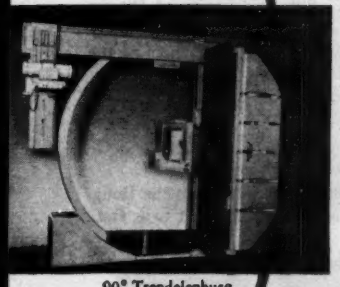
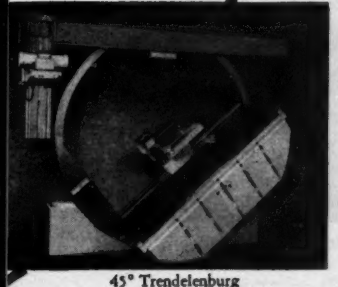


90° Trendelenburg



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GENERAL ELECTRIC

◂ Notes About People ▸

To Direct School of Nursing Dalhousie University, Halifax

Jean Grahame Church has been appointed as assistant director of the School of Nursing at Dalhousie University, Halifax. She succeeds Marion Pennington who has gone to Ankara, Turkey, as the representative of the World Health Organization.

Born in New Glasgow, N.S., Miss Church obtained her Bachelor of Science degree from Dalhousie University before she entered nurses' training at the Royal Victoria Hospital, Montreal. She later enrolled in the course in teaching and supervision at McGill University's School for Graduate Nurses, Montreal. She was educational director of the Childrens' Hospital, Halifax, and then organized a graduate and post-graduate program at the Nova Scotia Sanatorium in Kentville, N.S. Until her present appointment, she was a clinical instructor at Victoria Hospital, Halifax.

* * * *

Greater Niagara General Hospital Announces New Appointment

R. Ross MacKay has been appointed as assistant administrator and comptroller of the Greater Niagara General Hospital, Niagara Falls, Ont. Mr. MacKay commenced his new duties on October 1st. For six and a half years, he had been administrator of the Douglas Memorial Hospital in Fort Erie, Ont., and prior to that had occupied executive positions in an aircraft company and with a bond and brokerage business.

R. Ross MacKay

* * * *

New General Secretary-Treasurer of the Canadian Nurses' Association

In October, Myrtle Pearl Stiver assumed her new duties as general secretary-treasurer of the Canadian Nurses' Association. Born in Grey County, Ont., Miss Stiver graduated from the Toronto Western Hospital in 1932. She took post-graduate training in psychiatry and mental hygiene at Toronto Psychiatric Hospital and then was engaged in private nursing for several years. Later, she obtained her Bachelor of Science degree from Teachers' College, Columbia University. For two years Miss Stiver was on the staff of the Toronto Department of Public Health, after which she joined the Division of Venereal Disease Control of the provincial department of health as nurse epidemiologist. During the next six years she served with that division as supervisor, nurse consultant, and finally regional supervisor and consultant in venereal disease. In 1949 she was appointed director of public health nursing with the city of Ottawa department of health.

Miss Stiver possesses leadership qualities as well as a real flair for organization and administration, all of which will stand her in good stead in her new position. Outside her working day, Miss Stiver's interests are wide and varied, including photography, gardening and travelling.

* * * *

Appointments to Psychiatric Clinic at Ottawa General Hospital

The new psychiatric clinic which is being established at the Ottawa General Hospital, Ottawa, will be under the direction of Dr. Karl Stern who is a professor of psychiatry at the University of Ottawa medical school and psychiatrist-in-chief at the hospital.

Dr. Stern received his medical training at the Universities of Munich, Berlin, and Frankfurt and continued postgraduate work in psychiatry as a Rockefeller Fellow at the Psychiatric Institute in Munich. He was also a fellow of the Medical Research Council of Britain at the National Hospital for Nervous Diseases. Upon coming to Canada, he was with the Montreal Neurological Institute and later joined the staff of the Allan Memorial Institute. Dr. Stern has published numerous scientific papers and is the author of the best seller, "Pillar of Fire".

Joining Dr. Stern in the new psychiatric clinic are Dr. Victorin Voyer, Laval University, Dr. Wilson Van Dusen, and Dr. Agatha Sidlauskas, all of whom are also attached to the University's department of psychiatry. Dr. Voyer has studied in Montreal and Paris; Dr. Van Dusen received his training at the University of California and University of Ottawa; and Dr. Sidlauskas is a graduate of Kaunas University and the University of Milan where she held a professorship in child psychology. Dr. J. P. S. Cathcart, who has been doing clinical work and teaching at the University of Ottawa and Dr. G. H. Lugsdin, a University lecturer, will, also be members of the psychiatric clinic.

* * * *

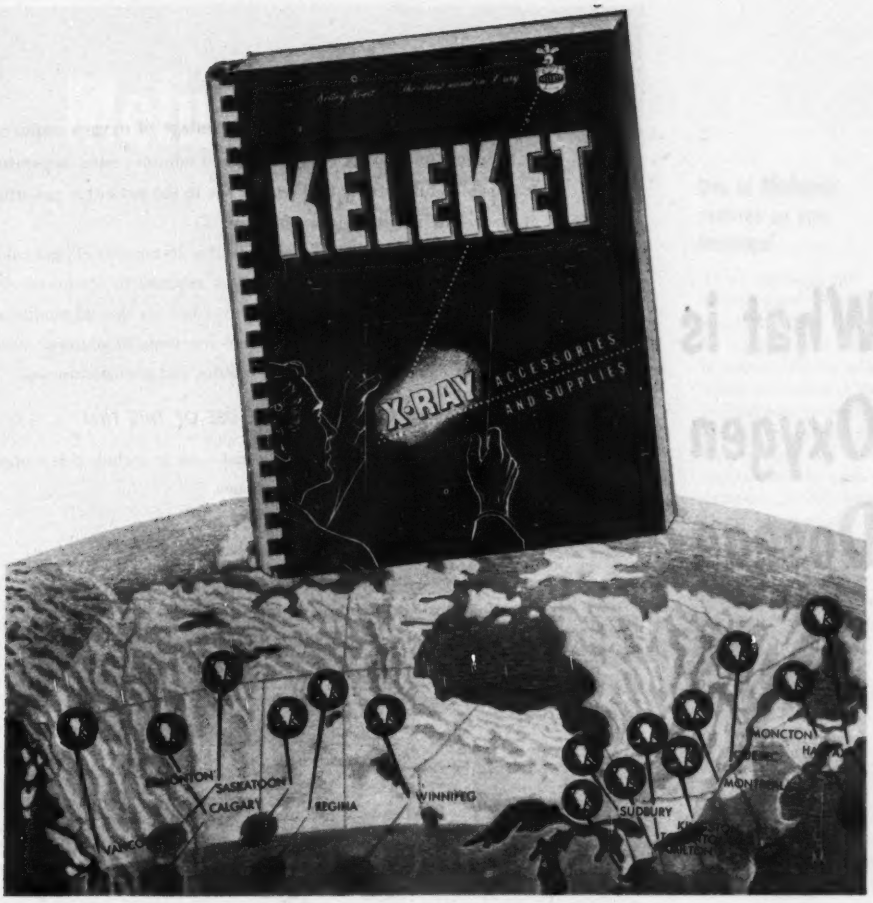
New Administrator Appointed at Douglas Memorial Hospital

The Board of Trustees of the Douglas Memorial Hospital, Fort Erie, Ont.,

Kenneth S. Meredith

has announced the appointment of Kenneth S. Meredith, as administrator. Mr. Meredith succeeds Ross MacKay.

(Continued on page 16)



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references:

1. A. W. Spittler, Col., (M.C.), U.S.A., J. J. Brennan, Lt. Col., (M.C.), U.S.A., J. W. Payne, Capt., U.S.A.F. (M.C.), American Academy of Orthopedic Surgeons, Jan. 26-31, 1952, Chicago, Illinois.
2. M. C. Cobey, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgetown University and Senior Attending Orthopedic Surgeon, Children's Hospital, Washington, D.C., The American Surgeon, Vol. XVIII, No. 4, April, 1952, pp. 413, 415.
3. M. C. Cobey, M.D., F.A.C.S., Washington, D.C., private communication.

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Notes About People

(Continued from page 12)

A native of Montreal, P.Q., Mr. Meredith received his education at McGill University, and at the University of Chicago, Ill. He served as assistant superintendent at the Montreal Convalescent Hospital and was also assistant and acting administrator of the Petersburg Hospital, Petersburg, Virginia, and administrator of the Bashline-Rossman Hospital in Grove City, Pa.

* * * *

Dr. Eva Macdonald Resigns from Women's College Hospital

Dr. Eva Macdonald has resigned her position as director of laboratory at the Women's College Hospital, Toronto, Ont., so that she may devote full time to general practice. At a tea held in her honour, Dr. Macdonald presented pins to the graduating class of laboratory technicians at the hospital and was in turn presented with a physician's bag. Dr. Macdonald plans to continue her work in the out-patient's department at the hospital. She is succeeded as laboratory director by Dr. Alice Gray.

* * * *

Hugh F. Ross, Administrator of Barrie Memorial Hospital

Hugh F. Ross has recently been appointed to the dual position of administrator of the Barrie Memorial Hospital, Ormstown, P.Q., and business manager of the Ormstown Medical Centre. Born in Toronto, Ont., Mr. Ross was graduated from the University of British Columbia, Vancouver, B.C., with the degree of Bachelor of Arts. After graduation, he enrolled in the post-graduate course in hospital administration at the University of Toronto and served his administrative residency at the St. Catharines General Hospital.

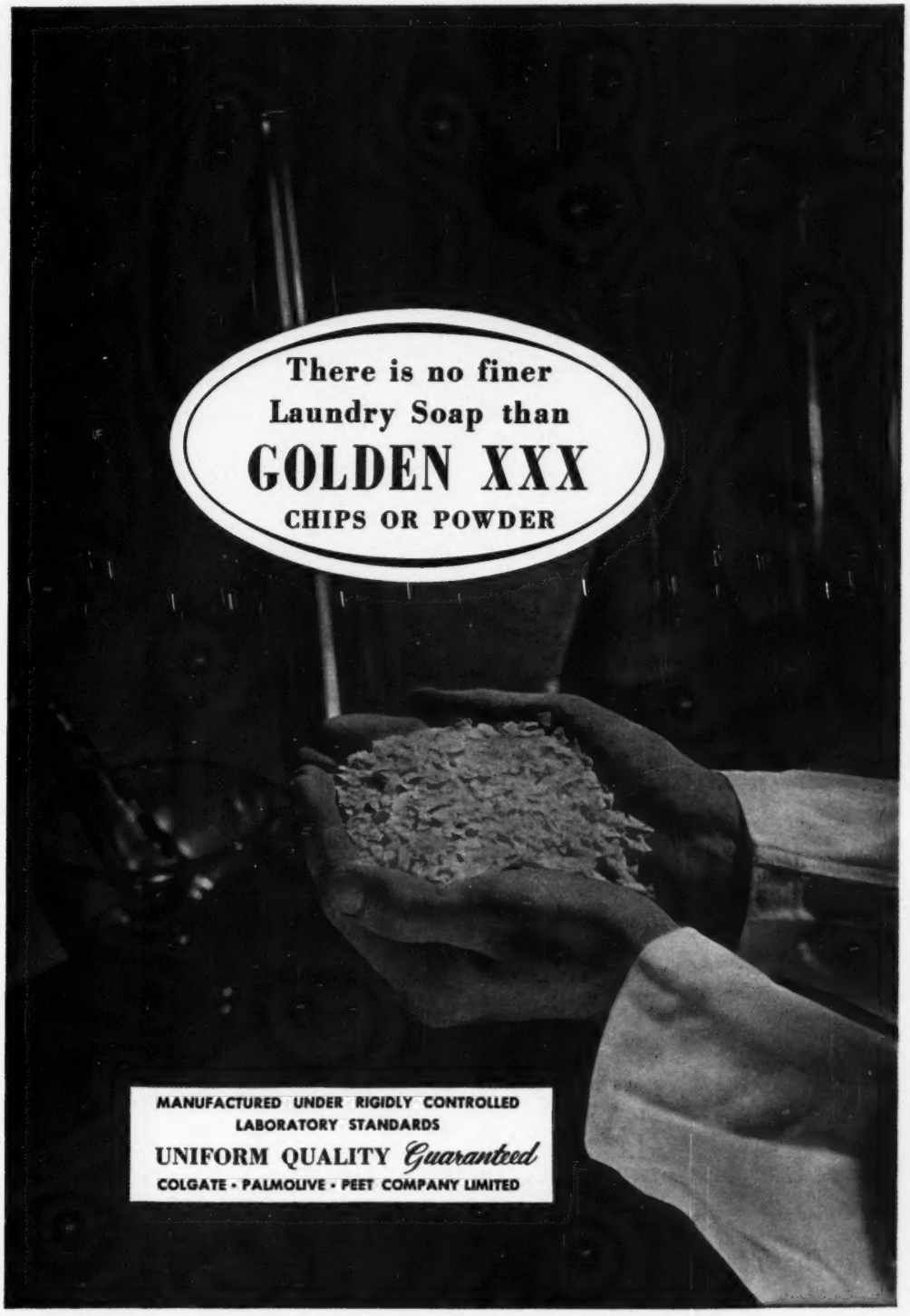
* * * *

● The Alexandra Hospital Trust has appointed Mrs. G. A. Boehner as superintendent of the Alexandra Hospital, Ingersoll, Ont. Mrs. Boehner had been superintendent of the Groves Memorial Hospital in Fergus, Ont., and assumed her new duties on Nov. 1.

* * * *

● Phyllis Lavinia Wylie has been appointed director of nursing of the St. John's General Hospital, St. John's, Nfld. Miss Wylie obtained her diploma in nursing education and administration from the University of Toronto,

(Concluded on page 104)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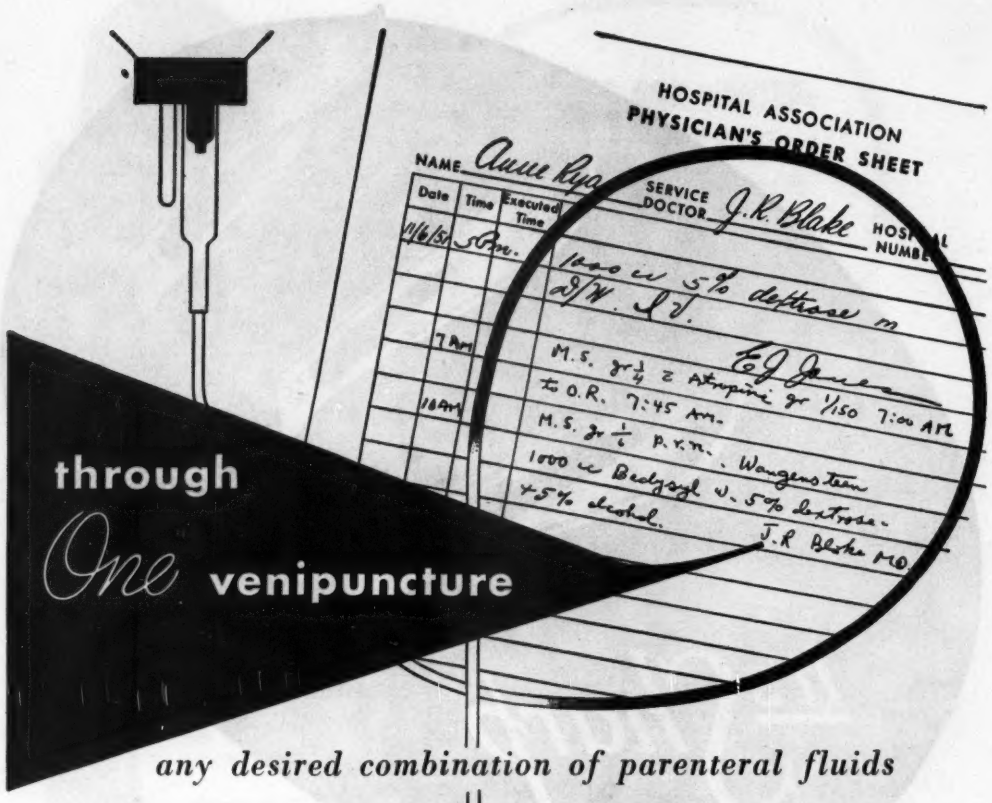

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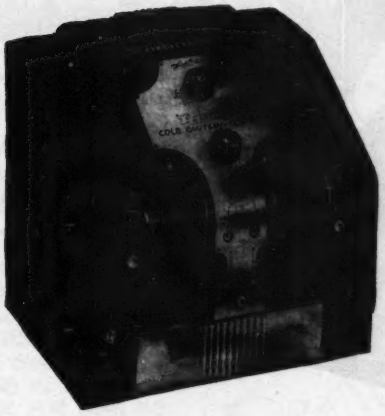

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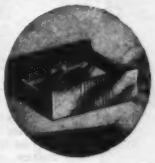

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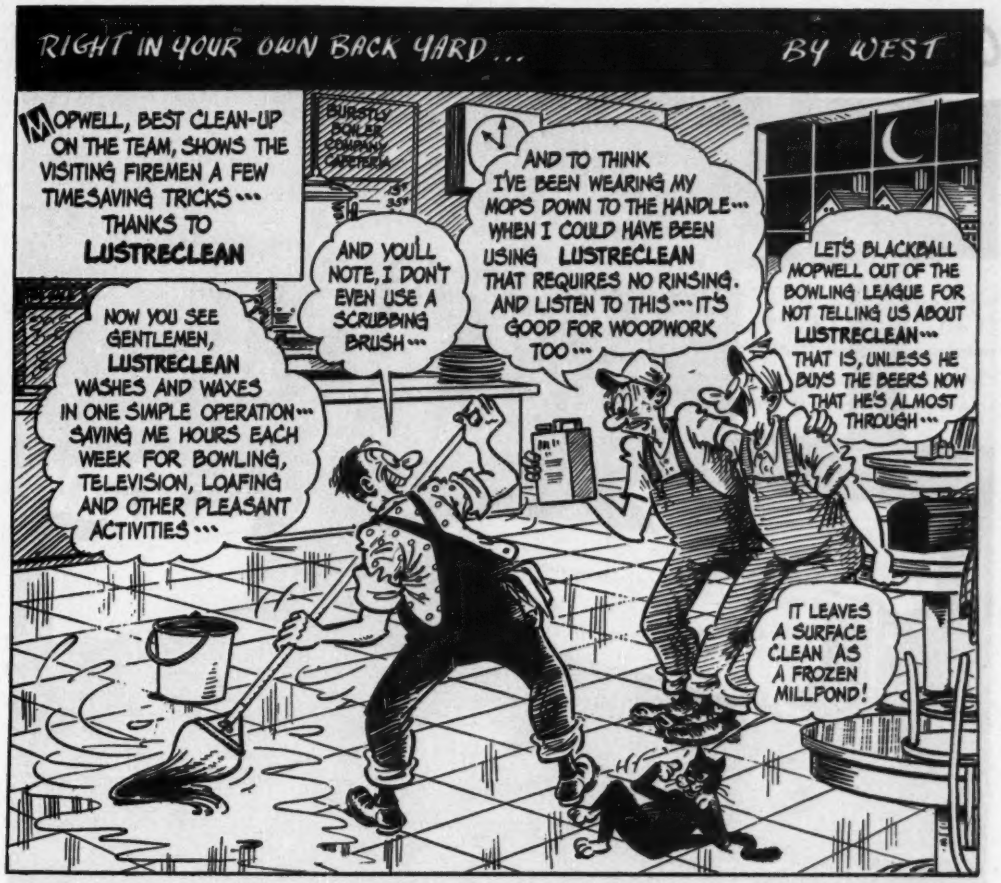

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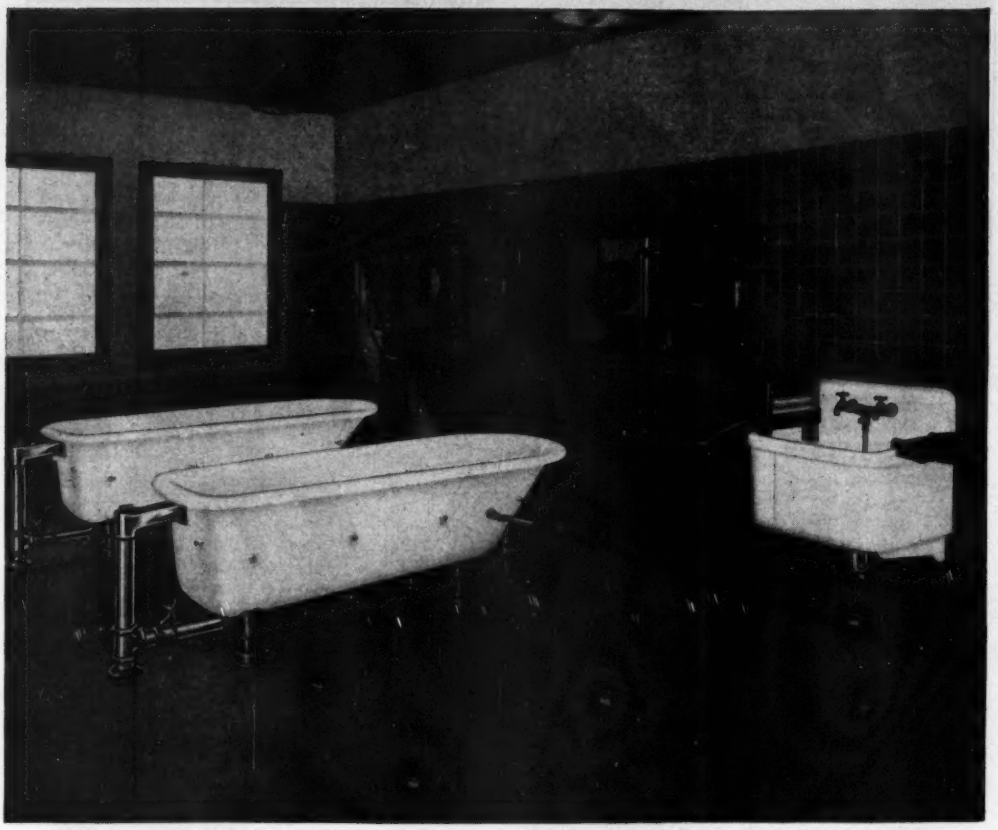

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A. L. Swanson, M.D., Editor

CANADIAN HOSPITAL

Toronto, November, 1952 Vol. 29 No. 11

Obiter Dicta

Are Old Prescriptions Crowding Your Pharmacy?

HOW LONG should prescriptions be kept on file in the hospital pharmacy? This question arises at intervals to plague every hospital administrator; yet, due to lack of definite provincial and Dominion rulings, it is never satisfactorily answered. Private pharmacists keep prescriptions for long periods — sometimes indefinitely — gradually filling up files and even rooms. Many hospitals follow a similar policy because of the vagueness of existing instruction, if any.

Some time ago *The Hospital Pharmacist* circulated a questionnaire including this query and found that no respondent was aware of any Canadian authority governing the length of time prescriptions should be kept. Later, in 1951, at a hospital pharmacy practice committee meeting in St. Louis, it was found that state regulations govern the matter in the United States. Several states require that prescriptions be filed for five years, with an additional two years for narcotics.

Following this meeting, the Canadian Hospital Council was asked for information concerning regulations in this country. Dr. L. O. Bradley sent inquiries to all provincial departments of health and the Department of National Health and Welfare. Nearly all departments have replied in similar vein. Some provinces make no mention of the issue in their hospital acts, leaving the decision to the individual hospital administrator. Others offer partial guidance with statements such as: "prescriptions for poisons and restricted drugs must be kept by the vendor". They may imply "indefinitely" but, presumably, the statutes of limitations of the province and the Dominion government would be some guide, since these limit the time in which legal action could be taken against the vendor.

Dominion statutes under the Opium and Narcotic Drug Act make no definite ruling. It is illegal for a pharmacist to refill prescriptions for narcotics and approximately two years allows ample time for the checking of prescription files by enforcement officers. By this reasoning, two years would appear to be adequate in point of time for keeping prescriptions. However, this is not definitely set down by the Dominion government and, were it to be, hospital administrators and pharmacists would still require positive provincial instruction.

It seems that the whole problem is a bit like the shrilling of a mosquito in one's ear when half asleep. Annoying though the insect may be, it is hard to rouse one's self to get up and track it down for the sake of a peaceful night. Similarly, when the question of retaining prescriptions is raised, we investigate, shrug our shoulders, and probably say, "Better keep them, just in case". The problem is not great enough to demand immediate action — the hospital will certainly function despite several thousand dusty old prescriptions filling up a set of shelves.

However, always assuming in this discussion that the prescription is set down on the patient's chart as well as on the pharmacist's prescription form, it would be helpful and the administrator would rest more easily, could he know exactly how long prescriptions must be kept in the pharmacy records. Present thinking is dictated by a vague fear that something might happen after the forms have been destroyed. We learn, however, that rarely are prescriptions referred to as far back as one year; the Opium and Narcotics Drug Act would apparently be satisfield with two years, and statutes of limitations are not overly long.

The Canadian Society of Hospital Pharmacists has taken an interest in this issue and will probably be pushing for a solution in co-operation with the Canadian Hospital Council, presumably with legal and governmental advice. This movement deserves the support of our hospitals and

governments in working out some formula for guidance. With such a formula, the over-crowded hospital pharmacy would gain needed space and the hospital administrator could swat that mosquito without getting out of bed.

Helping the Handicapped is Helping Yourself

IN TIMES of rising costs, we tend to be so busy watching where the money goes that we may miss some truly golden opportunities. The rehabilitation of the handicapped would seem to be one such opportunity which, in return for a relatively small expenditure of time, effort, and money, yields a great harvest — in the relief of others' suffering, pleasure in a job well done and, yes, actual dollars and cents.

The suffering of a handicapped person can be physical, as in arthritis, and/or mental and emotional torment. This latter form of suffering dulls the will, saps physical strength, and affects not only the cripple but the whole family unit. With a persistent disability, the almost inevitable depression that follows, and the resultant productive inactivity, the material resources dwindle until the whole family becomes either partly or wholly a ward of the state. Without assistance, the situation tends to become permanent and we have a helpless individual who suffers pain, unhappiness, and poverty, and is a financial burden to his fellows.

Dr. Howard A. Rusk, chairman of the department of physical medicine and rehabilitation of New York University College of Medicine, recently published figures proving that, in addition to the relief of pain and unhappiness, the rehabilitation of handicapped people likewise pays cash dividends. The income of 31 rehabilitated people who had been previously incapacitated by their disability and the potential earnings of 18 others in training for employment totalled, in estimate, $95,000. Without rehabilitation, most of the 49 would not have worked again. The cost of their rehabilitative care was approximately $175,000. Therefore, in two years the amount of their income would more than equal the cost of their re-training for independence.

It is true that some disabled persons can never work again and that others will be only partially self-supporting. On the other hand, literally thousands of handicapped people can be rehabilitated to an independent station in life and the remainder will benefit at least in improved morale. This type of rehabilitation is a benefit to society that cannot be described in financial parlance. Its humane worth is beyond calculation.

"This is all very fine," you may say, "but who is going to pay for this rehabilitation? Certainly the hospitals cannot assume a financial burden, such as this, no matter how great the social and economic benefit to these ununfortunate citizens." The answer to the problem lies in the very words — "unfortunate citizens". We, the more fortunate citizens, are beginning to realize our responsibility as a nation to care for our crippled fellow men and to formulate plans for their assistance. Hospitals and medical centres will have a prominent part to play as members of a team which is truly national in scope.

At the second meeting of the National Advisory Committee for the Rehabilitation of Disabled Persons, held in Ottawa, Sept. 23rd, and 24th, great inroads were made in this problem. The meeting was attended by members of the federal and provincial governments, together with experts in the medical field and representatives of most of the large rehabilitation societies.

The need for increased facilities and for many more personnel is clearly recognized as a prerequisite to placing a large national scheme in operation. Doctors, nurses, physiotherapists, occupational therapists, psychologists, placement workers, and others, will require special training. This costs money but our legislative friends are bending a sympathetic ear. Universities and hospitals will be asked to supply the time of experts and specialized training facilities. Working committees will be necessary to assess, the local, provincial, and federal resources, and to estimate additional requirements with the view to locating new centres or expanding present ones. These centres must be built, equipped, staffed, and organized to function effectively.

It is a tremendous undertaking — but the wheels are beginning to turn. Look about your hospital and your town, discuss the situation with employment officers, and be ready to help solve the problem. Every disabled person who is enabled to work and to produce is an economic gain to your town and to Canada. In addition, as the rehabilitated person and his family build a better and a stronger life, so is the very fibre of the country strengthened.

Harold Emerson Baird

This issue of the journal was on the press when word was received of the sudden death of a member of our Board of Directors, Dr. Harold E. Baird, Regina. See page 66.

Morale and Service dependent upon

Nursing Staff Personnel Policies

Sister M. Clarissa,
Administrator,
St. Rita Hospital,
Sydney, N.S.

THE PRIMARY objective of all hospital administration is better patient care. The hospital can accomplish this objective only through the efforts of *people* — the medium of *human* activity. Of the composite group which is essential to the functioning of the hospital perhaps no other person touches the patient more personally, more comprehensively, and more directly than the nurse. The graduate nurse — whether on general duty or as head nurse or supervisor — is fundamental to good nursing care.

Such being the case, it behooves us, as hospital adminstrators and trustees charged with the care of the patient, to ascertain if our nursing staff is functioning effectively with a view to patient welfare and, if not, why not? Quality performance, we know, cannot be obtained from the dissatisfied worker. It was the concrete realization of this fact that provided the impetus in more recent years for much significant study and research in the field of human relations. Hospitals are slowly but surely following in the wake of industry in applying these findings to their personnel problems. Considerable progress has been made by hospitals in attempting to frame policies and provide working conditions which answer to the basic "urges" inherent in human nature — the desire for gain, the desire for security, the desire for recognition and appreciation.

To obtain good attitudes on the part of employees, the basic personnel practices of the hospital must be essentially sound. There is no question but that the type of nursing service received by our patients is conditioned by the kind of personnel policies in effect in our hospitals. Enlightened policies, carefully formulated and properly administered, policies which meet the inherent needs and desires and goals of those who provide our nursing service, are undoubtedly one of the best levers in the hands of management today by which to raise the morale of our nursing staff so that they may render an improved quality of care to our patients.

Apart from this aspect altogether, from a purely business point of view, sound personnel policies have an actual dollars and cents value to the hospital. As hospital costs continue to spiral higher and higher, no doubt we are all seeking areas wherein we can effect savings. With payroll expenditures ranging from 60 to 70 percent of total operating costs, and with approximately 45 percent of total payroll going to provide nursing service, we should explore this area for possible savings. Future control of the payroll dollar will rest in more effective use of fewer (higher paid but better trained), more efficient, more satisfied employees.

Why the Rapid Turnover?

Rapid nursing staff turnover is admitedly expensive. It is recognized that the reduction in the efficiency of service and the loss of supervisors' time which result from frequent changing of personnel represent hidden costs. It is to be expected that there will be a certain amount of turnover among our nursing personel. The availability of positions almost anywhere, as a consequence of the prevalent general nurse shortage, the desire for travel, the desire for change, the lure of the wedding ring, are, and will continue to be, factors leading to turnover. However, these are not the only factors which cause nurses to leave. A greater percentage than we probably realize terminate employment because of poor personel policies, poor either in set-up or in practice. Thus, nurses are overworked because new procedures, which would change the total work load in a particular nursing unit, are not used; nurses are irritated because frequent changes are made in the time schedule, sometimes even at the last minute, and they cannot plan their social life in advance; nurses are antagonized because when they are on night duty no arrangements are made for them to get their pay cheques at a convenient hour but rather they are required to come to the hospital and stand in line at ten o'clock in the morning. Such conditions irk the nursing personnel and tend to breed discontent.

Sister M. Clarissa

What are Good Personnel Policies

Good personnel policies for staff nurses constitute a plan of action for every situation from commencement to termination of employment. They tell the nurse exactly what she is to expect from the hospital and, at the same time, what the hospital expects from her. These policies include job analysis, job grading, preparation of an adequate salary scale and ladder of promotion, adequate vacation and sick leave, preparation for department heads, and an adequate method of handling complaints and grievances. They should be so constituted as to nourish employee ambition and self-esteem by giving opportunities for advancement, by developing group consciousness, by remov-

An address presented at the third Maritime Institute for Hospital Administrators and Trustees, Halifax, N.S. November, 1951.

ing the fears of insecurity, old age, and similar threats to peace of mind. If the personnel policies are to serve the hospital and at the same time the nurse, it is essential that they be founded on equality and justice and assure a square deal to both. This can be effectively accomplished only by a clear-cut, *written* statement of policies —a statement that is consistent and understandable to the nurse. Even today, many hospitals have nothing "down in writing" for their nursing staffs. Written policies assure fair and equitable treatment, since they obviate the necessity of making a fresh decision in regard to each situation which is encountered or of depending on memory to recall procedures followed in like instances in the past.

Who is responsible for the formulation of personnel policies in the hospital? The governing board is the recognized policy-making body and this holds for the broad outline of personnel policy as well. Generally it is left to the administrator to develop policy content, to write specific regulations, and to see that they are put into practice in the hospital. In framing personnel policies, some consideration should be given to the factors that the nurse herself deems desirable. The administrator, as a rule, cannot judge the whole effect of any particular policy except by consultation with those who must live by that policy. Greater understanding, interest, and a better feeling of partnership, are shown if the employee's desires are considered. These may be gleaned in various ways, through an advisory commitee, conferences, or a questionnaire.

The primary aim, in setting up good personnel policies, is to obtain optimum correlation between the hospital's objectives and those of the nursing group. We must see that the patient receives the best possible care and that personnel of high calibre, who can do a skilful job, are attracted by good personnel policies.

Since hospitals vary in size, location, financing, and in service rendered, we cannot write standard policies applicable to all institutions. Each hospital must develop its own policies tailored to fit individual needs and conditions. Current practice in the community in which the hospital is located must be taken into consideration. Policies adopted should be consonant with general policies found in other hospitals or with those in force for similar tasks and responsibilities in that particular community.

Certainly the hospital's ability to finance the personnel program which is being developed is also of great significance. A hospital is and remains a *service* institution; it is non-profit. It must render service twenty-four hour a day, seven days a week, fifty-two weeks a year. It can produce higher wages and improved working conditions only at the cost of higher charges for hospital care. While endeavouring to provide conditions as ideal as possible for our personnel, we, as administrators and trustees, must also exercise due care not to allow costs to reach a point where resulting charges will be prohibitive for the patient. Ours is a dual responsibility — a responsibility toward those rendering hospital service and those who are the recipients of this service.

Functions of a Personnel Program

The complete personnel program includes the following functions which are familiar to all of us:

1. Employment
2. Induction and orientation
3. Opportunity, promotions and transfers
4. Compensation, including scale of increments.
5. Hours of work, vacations, holidays, leave of absence, et cetera
6. Employee health and safety
7. Termination of employment
8. Security—pension plans, et cetera
9. Employee participation.

Employment

This section should state policies regarding recruitment, selection, and placement. It should state clearly the probationary period and the conditions of advancement to permanent status; and it should include a definition of each type of employment, temporary, permanent, part-time. By selection we endeavour to assess the suitability of the applicant for the position, while placement involves fitting the nurse into the total work situation. Her position should be well defined and her duties explained to her at time of employment.

Induction and Orientation

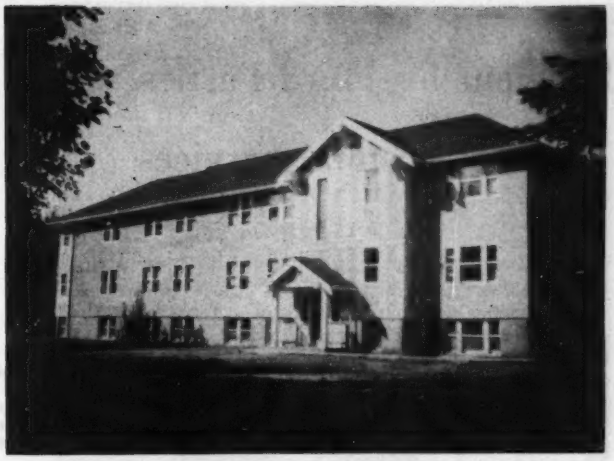
Induction involves the actual introduction of the nurse to her new position. In the orientation program she is made acquainted with the non-technical details of her work, the ward to which she is assigned to duty, its physical set-up, its staff (including the doctors), and the patients for whom she will be responsible. A graduate of another school must be oriented to the particular routine and procedures used in the hospital. She should be shown the location of the linen room, the pharmacy, and any other departments she might have to visit from time to time. Regulations as to when prescriptions are filled, reports which must be submitted to the admitting or business offices, and all similar regulations should be made known to her. Such a planned orientation program will eliminate that "lost" feeling a new nurse experiences when it is left to her to find out as best she can just what is expected of her — a feeling which generally leads to lack of interest, frustration and, often, a desire to leave as soon as possible. With a successful adjustment, the nurse is given a sense of confidence and security in the beginning. A good orientation program takes time to plan and carry out but it does pay dividends in nurse morale.

Promotions and Transfers

It is important that promotional policies provide for the selection of the most suitable (not necessarily senior) nurse to fill a vacancy. Seniority should be given consideration only if abilities are comparable or equal. One of the primary desires of the individual is for advancement and self-improvement and, therefore, one means of assuring a satisfied employee is through the use of her highest skills with the opportunity open for her to advance in the organization. We must admit the lack of promotional possibilities in hospitals is a major problem in the retention of good nursing personnel. Professional advancement is necessarily limited. It is unfortunate that we cannot think of advancement on a horizontal as well as a vertical plane.

It is highly recommended that we endeavour to establish a rating plan whereby we can evaluate the nurse's progress and determine as objectively as possible if her skill is being utilized to best advantage. This objective evaluation of her work can be used not only for a basis for promotions and salary increases but also for counseling. The nurse should be made aware of her progress or deficiencies. Constructive criticism is necessary at times and we are not playing the game with our staff if we do not offer them con-

For Comfort and Contentment



Nurses' residence at High River, Alberta

A LONG-AWAITED dream came true when the nursing staff of the High River Municipal Hospital, High River, Alta., moved into their new $95,000 residence in May. The three-storey building, furnished and equipped with all the essentials necessary for the comfort of the nurses, was officially opened and inspected by the people of the district at the end of July.

Two entrances give access to the building, which is approximately 100' by 30'. On the main floor, in the north-east corner, is the spacious, "L"-shaped living room; one wall is panelled in birch and the other three are painted grey. The contrasting white ceiling has acoustic properties and woodwork is in a natural finish. Maple furniture, with sponge rubber upholstery, is arranged so that several groups of people may be entertained at one time. The hardwood floors are covered with rugs which harmonize with the fibre glass drapes. A large fireplace adds to the cosiness of the room, which may be completely closed off from the rest of the building.

A small kitchen, adjacent to the living room, is equipped with an electric stove and refrigerator. This room is gaily decorated in horizon blue and primrose yellow and the floor is of asphalt tile.

A three-room suite, on the south side facing the hospital, has been set aside for the superintendent. Here, the sitting-room has been decorated in melon, with complimentary drapes of fibre glass. The bedroom contains a beautiful maple suite and the adjoining bathroom is in delicate pink.

Eight bedrooms are located on the main floor. The walls of these rooms have been painted in bay leaf green and the floors are covered with gray carpeting. Gold fibre glass drapes with a jungle orchid design have been chosen to complete the colour scheme. One entire wall of each room is set aside for a wardrobe, drawers, cupboard, and shelf space, all built-in to dovetail into the plan of the adjacent room. A dressing table, with a large mirror, a vanity chair, and hostess chair have been placed in each room.

On the second floor are 14 bedrooms. Here, the colour scheme consists of dusk rose walls, green carpets, and aqua drapes with the same jungle design as in the rooms on the main floor.

On each floor there is a large bathroom, equipped with three sinks, three toilets, a bath, and a shower. Ceilings in the bathrom are white and the walls have been painted in graduating shades of blue. Space has been provided for utility closets on each floor and a large linen cupboard on the first floor is used for all the bedding needed in the residence. A trunk room and laundry facilities are located in the basement.

The comfortable living accommodation provided by the new residence has checked wanderlust on the part of the nursing staff and has attracted more nurses to the hospital. In fact, as of September, High River Municipal Hospital had a list of applicants waiting for vacancies.

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structive leadership. Personal as well as professional interest in the nurse should stimulate her to greater effort and bring out latent qualities.

Compensation

Detailed salary schedules should be written into the personnel policies, together with increases for advancement in rank, merit, and length of service. The hospital's policy with regard to over-time compensation should be clearly stated. In general, the salaries offered our nursing staff should be consistent with those of comparable professions. The trend toward paying nurses gross salaries and having them purchase the services which they now receive as perquisites has to my mind much to commend it. It would help to offset the popular tradition that nurses' salaries are so sub-standard. It is surprising how rare it is to find the nurse who remembers that when she receives her pay cheque she receives, in addition, at least two meals each working day, her morning coffee and afternoon

(Continued on page 112)

Payment by Third Parties for Hospital Services

A. H. Westbury,
Assistant Director,
Montreal General Hospital,
Montreal, P.Q.

FOR MANY YEARS a number of hospitals used the term "revenue from patients" to denote that part of their income derived from earnings. It is more in keeping with present-day conditions to change this term to "revenue from or in respect of, patients", or better still "earnings from services to patients". This more clearly expresses the fact that hospitals are selling service in the same way as a business-man sells commodities.

The days when hospitals were regarded as havens for the sick poor only have gone. Nowadays all classes of the community use hospitals. This situation has been brought about by increased recognition that medical treatment can be given more advantageously in hospital than even in the most luxurious home, lacking hospital equipment and specially trained staff, and by the rapid growth of voluntary pre-payment plans. The charges for hospital service are governed, in general, by the buyer's financial means and by the degree of service.

It should be recognized that, in the future, the proportion paid by patients themselves for hospital services will decrease and that paid by third parties on behalf of patients will increase. This should prompt all hospital administrators to examine and give close attention to the bases upon which third parties pay for hospital services.

In Quebec, the principal agencies who buy hospital services are:

(a) Federal government—which is responsible for the hospitalization of veterans, mariners, Indians and Eskimos.

(b) Provincial and municipal governments —which under the Quebec Public Charities Act accept joint responsibility for the hospitalization of those medically indigent patients who come within the provisions of the Act.

(c) Workmen's Compensation Commission —which is responsible for the medical care and hospitalization of employees injured at work.

(d) Voluntary group hospitalization plans—either "Blue Cross" or group plans underwritten by commercial insurance companies.

The principle upon which each of these agencies buys hospital services differs from the others, either in the amounts paid or the basis upon which payment is determined.

The Federal Government

A peculiar situation in regard to payments to hospitals by the federal government is that there is no uniformity in the rates paid by the various departments to the same hospital for similar service. The Department of Veterans' Affairs usually pays the full rates set forth in the hospital's tariff for bed, board and extras. On the other hand, the department which manages the Sick Mariners' Fund pays a lower daily rate and recognizes only certain extras, while the department responsible for the hospitalization of Indians and Eskimos pays a daily rate arbitrarily established without any consideration for extra services.

A. H. Westbury

The basis upon which these payments are made is wrong, for these departments are taking advantage of the voluntary hospitals' traditional policy of establishing rates for public ward accommodation at less than cost for those who are unable to pay the full cost. Any method of reimbursing the hospitals at less than cost for services to patients for whom a governmental agency is responsible is indefensible. As a general principal, a voluntary hospital is entitled to receive payment in full from the government for services which the government itself would otherwise have to provide. The basis of payment should be "full cost" including an allowance for depreciation, interest and use of capital.

For the fact that they do not receive full cost, hospitals themselves must take part of the blame, for a large number are unable to determine what the actual cost of service is. The first step is the establishment by all the hospitals of a uniform system of computing the cost.

Because of the various conditions which prevail between hospitals, even of the same size and type, uniform accounting will not necessarily result in uniform costs. A uniform *method* of arriving at costs, however, will considerably strengthen the hospitals' right to request full payment by governmental agencies. Moreover, if the voluntary hospitals can convince the various agencies of the federal government that they are entitled to full payment for services, then representations to provincial and municipal govrnments for greater assistance will also be strengthened.

Provincial and Municipal Governments

Under the provisions of the Quebec Public Charities Act it is laid down that "the cost of maintenance of the custody and of the treatment" of indigent patients requiring hospital care shall be borne one-third by the province, one-third by the municipality in which the patient resides, and one-third by the hospital. In establishing that part of the cost which shall be borne by the hospital, the legislators recognized that the charitable aims of the voluntary hospitals should be retained. Whether the hospital's share should be as high as one-third, how-

(Continued on page 82)

An address delivered at the hospital conference of the American College of Surgeons sectional meeting in Quebec City, February, 1952.

Saskatoon's Cobalt Therapy Unit

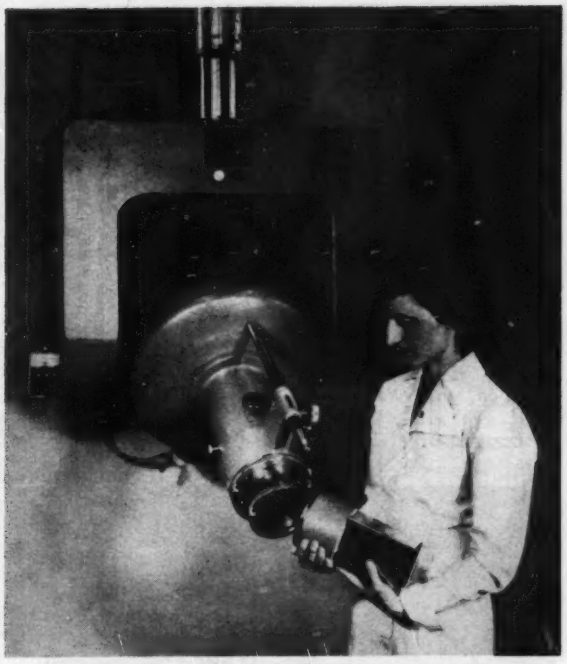


Figure 1: Cobalt 60 Unit

A 1,000 curie cobalt 60 unit was installed in the new, partially-completed University of Saskatchewan Hospital in Saskatoon, August, 1951, and the treatment of patients began in November. This unit provides radiation equivalent to that produced by a three million volt x-ray machine and is expected to provide several advantages in the treatment of some kinds of malignant disease. These advantages over conventional x-ray therapy include:

1. A very high depth dose, *i.e.*, a large proportion of the x-rays reach deep tissues compared with the incident skin dose.

2. Differential absorption of tissues (such as bone and cartilage compared with muscle and fat, et cetera) is much reduced; hence there should not be the same danger of bone or cartilage necrosis.

3. The skin effect for the same incident dose is less; mainly because the maximum dose is not received until a depth of 4-5 mm. is reached.

4. The integral dose for irradiation of a given volume of tissue is less.

5. The initial cost and upkeep are low.

This unit was manufactured for the Saskatchewan Cancer Commission to our design by the Acme Machine and Electric Company of Saskatoon. The cobalt was activated by the Isotope Production Branch in the Canadian pile at Chalk River, Ont. A photograph of the unit is shown in Figure I.

The Cobalt 60 Source

The essential part of the apparatus is, of course, the cobalt 60, which possesses several advantages over radium for this purpose. The cost alone of an equivalent amount of radium would amount to many millions of dollars. This amount of radium, moreover, would be physically so thick that most of its radiation would be lost by self absorption. The cobalt source, which is made intensely radioactive in the atomic pile, consists of 25 discs, 0.5 mm. thick and 2.5 cms. in diameter. These discs were sealed into a stainless steel cup at Chalk River and screwed on to the end of a "heavy metal" cylinder (see insert in Figure II). Subsequently, this cylinder, containing the cobalt at one end, was handled as one unit.

T. A. Watson, M.B., Ch.B., D.M.R.,
Director of Cancer Services for Saskatchewan,

H. E. Johns, M.A., Ph.D. (F.R.S.C,).
Saskatoon Cancer Clinic,
Saskatoon, Sask.

Treatment Head

Essentially, the treatment head consists of a sphere of lead with a hole in one side to allow the gamma rays to escape in one direction only — see Figure II. The lead is enclosed in a steel shell 20 inches in diameter and 22 inches high. In the centre is a steel-encased lead wheel which can be rotated by a small electric motor, by remote control. The "heavy metal" cylinder, containing the cobalt at one end, was inserted into a hole in this wheel by pulling it up from the top of the whole unit with a rod and then screwing it permanently into place. The lead plug, in the top of the unit, was then replaced and the wheel rotated so that the cobalt no longer was opposite the opening in the bottom of the unit. In this "off" position, no more than minute amounts of radiation (below tolerance limits) penetrate the lead container.

At the "open" end of the unit a hollow cylinder is fitted, which collimates the beam and allows, with dif-

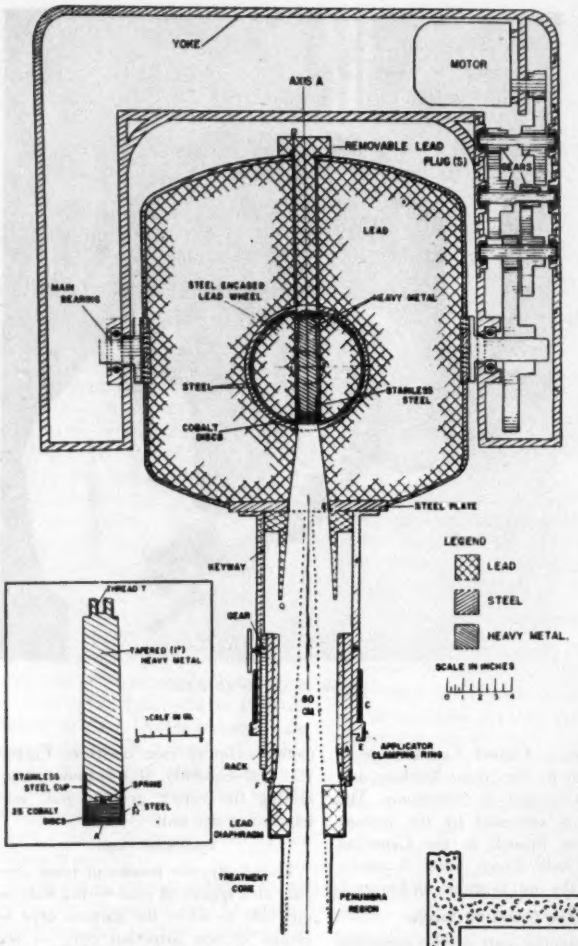


Figure II: Schematic Diagram of Unit

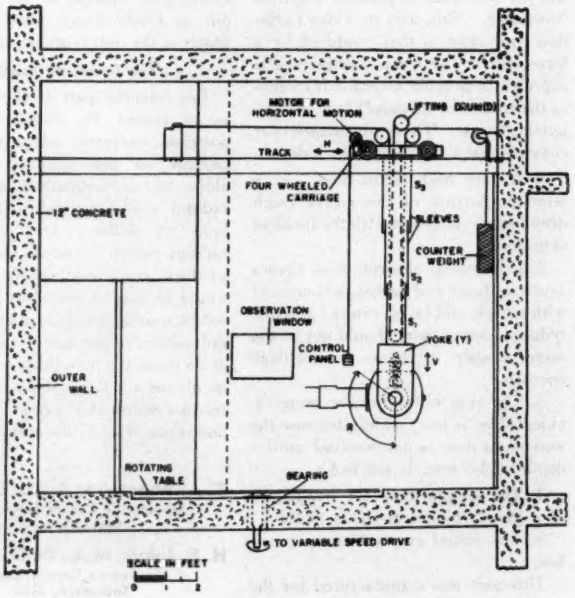


Figure III, right: Method of Suspension from Overhead Rails

fering fixtures, the attachment of treatment cones varying from 5 cms. x 5 cms. to 20 cms. x 10 cms. at a source-skin distance of 80 cms. Also built into this cylinder is a universal attachment for accessory equipment, to be described later. The diameter of the source (2.5 cms.) means that a penumbra at the edge of the field is, of necessity, present. By the collimating device used, this is limited to 6 mm.

Mounting of the Unit

The whole unit is suspended from a carriage on two steel rails near the ceiling. This carriage can be moved forward or backwards by a small electric motor. The unit, which can be moved up or down by a motor, is counter weighted by steel cables carried over to weights on the wall. A schematic diagram of the installation is shown in Fig. III.

Rotation of the unit is again accomplished by an electric motor. All of these movements are controlled by a small hand box, suspended freely from the ceiling, containing six push buttons. In this way, positioning can be quickly and effortlessly accomplished.

Operation of Machine

The machine is operated from outside the room. Beneath the viewing window is a control panel set into a

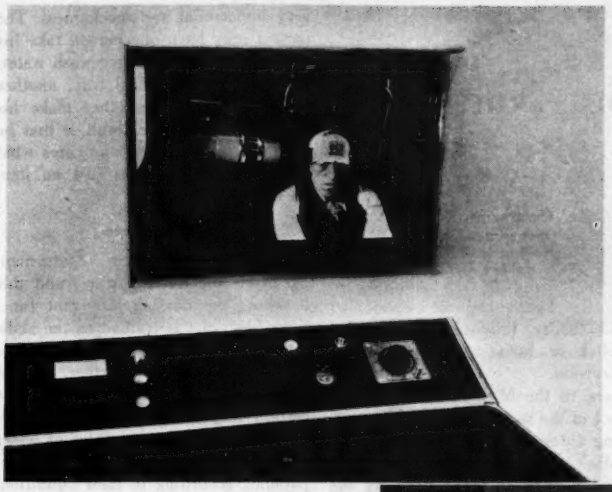


Figure IV, above: Control panel and Observation Window

table. This contains an electric timing clock, a key, and two coloured lights. Before the cobalt can be rotated to the "on" position, the doors to the treatment room, by a system of interlocks, must be closed and the key turned on. The clock is then set to the required exposure time and the "on" switch of the clock moved. Immediately, the wheel inside the unit starts turning. When it reaches the "on" position (3 seconds) the clock starts. When the required time has elapsed, the cobalt automatically rotates to the "off" position. If a person should enter the room during treatment the clock stops and the cobalt rotates to the "off" position. Figure IV shows a patient

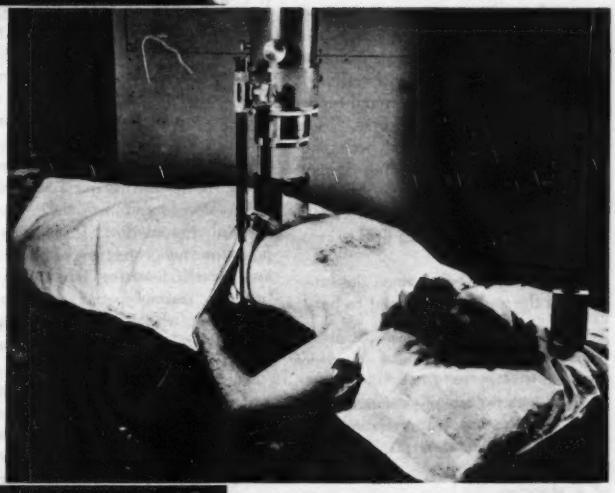
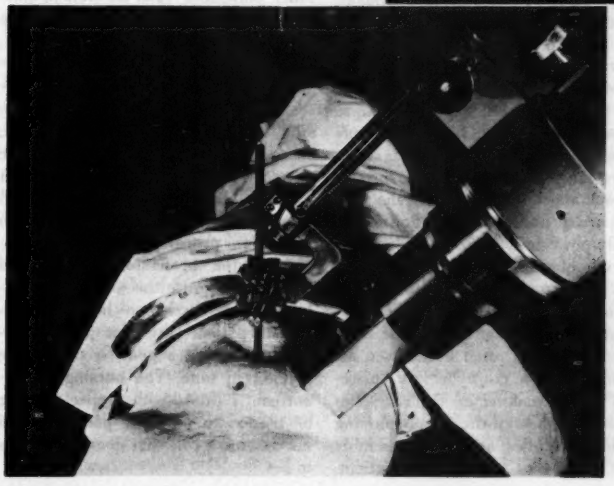


Figure V, right: Compression in Use

Figure VI, below: Pin and Arc in Use



receiving treatment, viewed through the eight-inch glass window. The control panel is in the foreground.

Accessory Equipment

Several gadgets, which may be screwed to the treatment head when required, are provided.

(a) In ordinary set-ups, where compression is desired, a simple attachment to the master cone allows one to determine accurately what compression is being used (Figure V). The setting is noted and can be exactly reproduced, daily.

(b) For beam direction, using plaster casts and wax seatings, a back pointer is attached (Figure IV).

(Concluded on page 86)

Pro's and Con's

The Practical Nurse

Sr. Catherine Gerard,
Superintendent,
Halifax Infirmary,
Halifax, N.S.

FOR the past ten years there has been a great deal of controversy about the "practical nurse". We now all seem to agree that there is definitely a place in home and hospital for these trained auxiliary workers in the field of nursing.

The Canadian Nurses' Association has a committee now studying the question. They recommend that the official title be "Nursing Attendant" and define the term thus: "One who has graduted from a recognized school for nursing attendants and who can assist with the care of a patient in hospital or home, under the direction of a physician, or the direction and supervision of a registered nurse." The title "practical nurse" has been subjected to much abuse, by being claimed by persons with little or no training. The official definition, and the adoption of the new title should help to remedy this.

The committee has defined the functions of the nursing attendant to be:

To assist with the care of patients in hospitals under the direction and supervision of a registered nurse.

To assist with the care of patients in homes under the direction and supervision of a registered nurse or, where the patient does not need a registered nurse, under direction of a physician.

To practice hygienic care of the patient's environment and where indicated, the required care of the home.

The general pre-entrance requirements for the schools that are being set up are: age 18 to 40 years; at least Grade IX education; a regular health examination is to be carried out, as is required for all nursing students. Probably the pioneer work, on any large scale, was in the State of Michigan, where they have developed two types of training program: (1) The hospital school, usually three months of classroom instruction and six to nine months of supervised practical work; and (2) The vocational school, 16 weeks' theory, followed by 31 weeks' hospital or home experience under supervision.

Here in the Maritimes, we have a school of the second type, at Moncton, giving three months' theory and six months' supervised hospital practice. Valuable work is being done by the Department of Veterans' Affairs in developing these schools. On completion of her course, the nursing attendant may expect to receive a salary about 70 per cent of that of a professional nurse.

There is need for a certain amount of legislation in this question and it is being considered by the Canadian Nurses' Association. It is necessary both for the protection of the attendant herself, assuring her status as a properly trained person, and for the protection of the community against those untrained persons who pose as "practical nurses".

There is also a need for some public relations activity to develop an understanding in the public mind, and in the mind of the professional nurse also, of the place of the nursing attendant, so that she may be neither despised nor over-rated. There are definite limitations to what she is expected or allowed to do; but within her limitations she can make a splendid contribution to patient care. In the home, she may assist a registered nurse; or, in cases where the patient is a chronic invalid without alarming symptoms, she may work alone under the direction of the family physician.

In the hospital, the problem is somewhat more complicated. Just where within the organization does the nursing attendant belong? In the past, these helpers have too often been given assignments on a more or less "piecework" basis making an endless series of beds, and so forth. Some nursing service schedules are real "assembly lines" that must seem, to the patient, very impersonal and mechanical. The patient may have one person take his temperature, another give wash water, another carry his meal tray, another give his medicine, another make his bed, and so on. The result is that he does not feel that any one cares what happens to him—he is just an item on the assembly line.

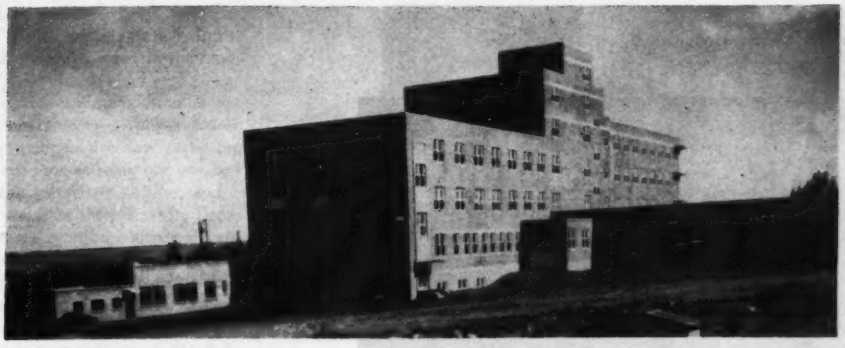
Nursing Team

Far better than this, if we can manage it, is the nursing team, and this is where the nursing attendant functions best. She is trained in the skills rather than in the theory of nursing—she must be a junior partner. Certain decisions are not hers to make, nor certain responsibilities hers to worry over. She will have a greater or lesser share in the care of the individual patients, according to their condition. For the acutely ill patient, she may be permitted to do very little; for the "chronic" patient requiring no special active treatment, she may give almost total nursing care, always, of course, under direction. In this way, the nursing attendant is given an opportunity to develop her particular skill in the nursing arts, and she is happy in the knowledge that she is making a real contribution to the care of the sick.

The professional nurse is freed from many time-consuming tasks and has an opportunity to exercise such talents of ward management and teaching as she may possess. Between the two, the patient receives the optimum care with not too many different persons bothering him. Of course, we realize that the nursing team will also include other personnel, such as student nurses, and possibly auxiliary workers on the housekeeping level whom the C.N.A. wish to designate as "ward maids."

At present, many professional nurses have a certain fear of the "intrusion" of the nursing attendant in the field of nursing; they fear that these people will be taking employment that properly belongs to the registered nurse. However, we shall find that with legislation, proper planning and co-operation, the professional nurse will come to recognize the worth of the attendant and welcome her contribution to patient care. For perfect harmony, we need a good second fiddle playing in tune. The nursing attendant can, I think, with proper training be trusted to play her part well and not assume a role that does not belong to her.

An address presented at the Maritime Hospital Association convention, St. Andrews-by-the-Sea, N.B., June, 1952.



Administration offices are in low annex to the right, boiler house and laundry building to the left.

Keeping Abreast of Medical Progress

New Swift Current Union Hospital

E. V. Wahn,
Superintendent,
Swift Current Union Hospital,
Swift Current, Sask.

JUNE 23rd, 1952, was an important day for the citizens of Swift Current and surrounding district, since it marked the official opening of their new union hospital. Replacing an older institution which had served the community since 1912, the modern new hospital contains 114 beds and 29 bassinets.

Why and How

Since the early 1930's there had been an increasing demand for hospital beds in the Swift Current area. However, drought and depression plagued the southwestern area of the province during the mid 30's and World War II broke out in 1939 — all these factors making it financially impossible to build an extension to the overcrowded hospital. By 1941, however, the lack of beds had become so acute that construction was commenced immediately and by the end of 1942 an additional 24 beds were made available in the east wing.

While this addition helped somewhat, it fell considerably short of providing the people of Swift Current and district with the type of hospital service considered desirable. Laboratory and x-ray facilities continued to be inadequate and incapable of providing, satisfactorily, a comprehensive range of diagnostic service. This situation was realized by members of the hospital board and medical staff, as well as by most citizens of the area. As a result, community activity began to be directed towards the establishment of a new modern hospital. By 1944, investigation on the part of interested people made it apparent that this new hospital should be of at least 100-bed capacity. Further investigation revealed that the construction of such a hospital was not within the financial resources of the citizens of Swift Current, alone. Because almost 50 per cent of the patients hospitalized in the old building were residents of rural areas adjacent to Swift Current, it seemed only logical and fair to ask them to contribute financially toward the cost of building a new hospital. Subsequently, an agreement was reached with representatives of neighbouring municipalities to organize under the Union Hospital Act, a board was appointed, and the Union Hospital District was formed in 1947. In 1948, the services of H. K. Black, a Regina architect, were obtained, plans were drawn up for the hospital, debentures were issued and approved, and construction commenced shortly.

Facilities of the New Hospital

Of brick and reinforced concrete construction, the new hospital is four and a half storeys high, with a one-storey annex containing administrative offices. Just east of the hospital, connected by a tunnel, is the building housing the boilers and laundry.

In the basement of the main building are kitchen and cafeteria, general stores room, furniture stores room, several locker rooms, three classrooms, and medical records storage. In the old hospital, the kitchen and dining room were crowded into a dark corner; in the new hospital, the space allotted for dietetic service is almost quadrupled. There is an investment of $25,000 in the new equipment and stainless steel predominates throughout the area. There are three walk-in refrigerators as well as a refrigerated room for garbage storage. Electric dumbwaiters convey food to the patient floors and the staff receive their meals in the bright cafeteria, a section of which can be blocked off by sliding doors. Thus various groups, such as the medical staff, can lunch in private if they wish.

On the ground floor, there are two waiting rooms, business and administrative offices, x-ray, laboratory, and physiotherapy departments, the pharmacy, the paediatric ward, and some patients' rooms. The x-ray department

Above: a well furnished 4-bed ward.
Right: a view of a private room.

is divided into two rooms, one equipped with a 500 MA unit and the other with a 200 MA unit. In the new laboratory, there is approximately five times as much space available for procedures than there was in the old one.

In contrast to the one room which had been used as a paediatric unit in the old hospital, there is a separate suite for children in the new building which contains 14 beds. Completely segregated from the rest of the adult wing on the same floor, the children's section has its own admitting room, two semi-private wards, a six-crib ward, a nursery section for very young children, and a utility area with toilet, bath and sterilizing room.

The second floor contains the operating room suite, central sterile supply, and patients' rooms. Facilities on the third floor include two delivery rooms, nurseries, and maternity beds. The fourth floor is reserved entirely for patient accommodation while the fifth floor is a penthouse and includes intern's quarters.

There are three operating rooms in the new hospital, whereas there was only one in the old building. Walls are of eye-rest green tile, floors are of static-proof tile, and oxygen and nitrous oxide are piped to each room. Two recovery rooms have also been provided, another "first" in the hospital, for this area.

Other improvements and features in the new hospital include an additional delivery room and three more nurseries. The nurseries, which have separate cubicles, are equipped with oxygen and suction outlets. The physiotherapy department is entirely new as there was no provision for this service in the old hospital. Central sterilization is being carried out for the first time too since, formerly, each nurse had to sterilize the instruments she needed, separately. The pharmacy department boasts much new equip-

ment and the medical records room, on the main floor, has a spiral staircase leading to a storage room in the basement.

The type of accommodation is another improvement. Approximately half of the patients are now cared for in four-bed rooms, with one six-bed room in the paediatric section, and a three-bed room on the maternity floor. The rest of the rooms are either private or semi-private.

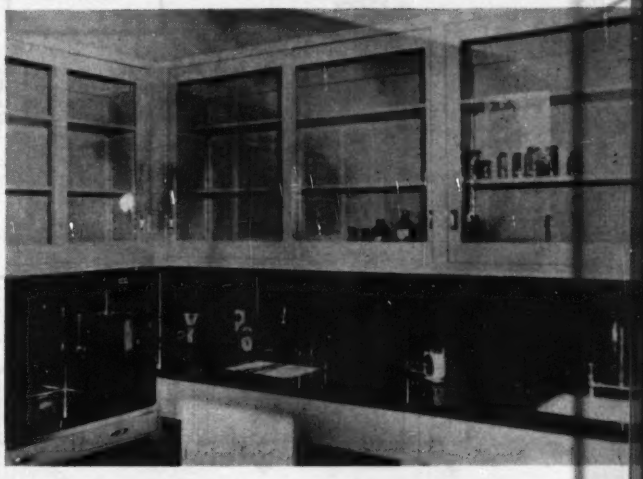
Innovations have been made, as well, in decoration and furnishings. An inviting, green pastel has been used effectively in many areas of the hospital. The public wards are spacious, well lighted, and painted in pastel tones. Floors are tiled for easy cleaning, radiators are recessed, and each ward has fresh air ventilation through ducts near the ceiling. Individual clothes cabinets permit patients to keep their possessions right in the ward. Private and semi-private rooms have similar features in addition to bathroom facilities.

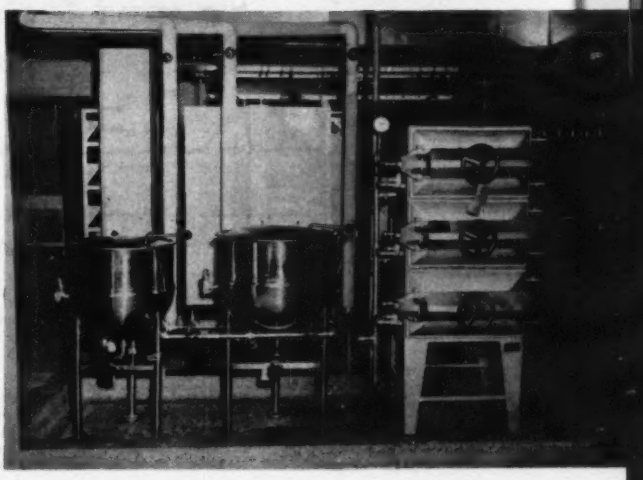
More space has been provided in the new hospital for visitors, from the large lobby on the main floor, to the various waiting rooms. One waiting room is near the x-ray department and the laboratory for the convenience of outpatients; while there is at least one pleasantly decorated room on each floor where up-patients can entertain visitors. The comfort of staff members has not been forgotten either, since pleasant lounges have been provided for their use. Considerably more space has been devoted to business and administrative offices; and a photo-fluoragraphic unit is located in the main admitting room so that each patient can be routinely screened upon admission.

The new heating plant, located in a separate building, contains two 60 H.P. oil burners. The laundry, in the same building, is another boon to the hospital, as in the past, laundry was always sent to Regina.

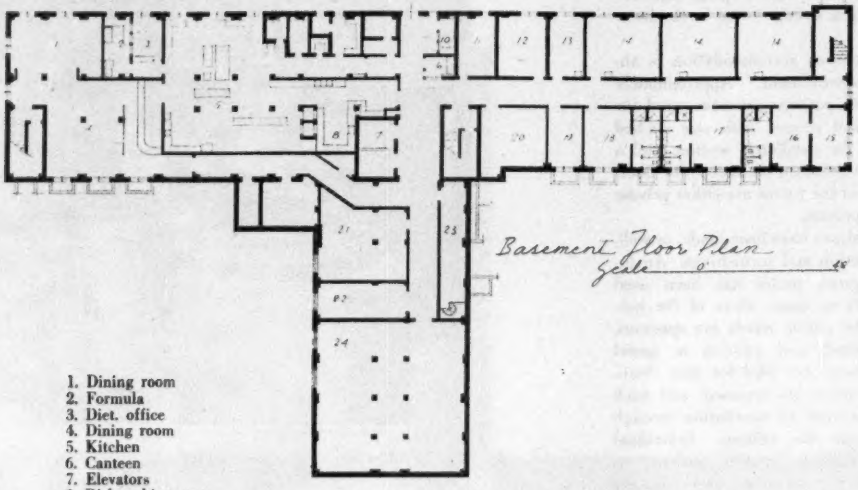
The total cost of the new hospital is approximately $850,000. For the present time, the old building is being used to accommodate the nursing staff.

(Floor plans on two pages following)

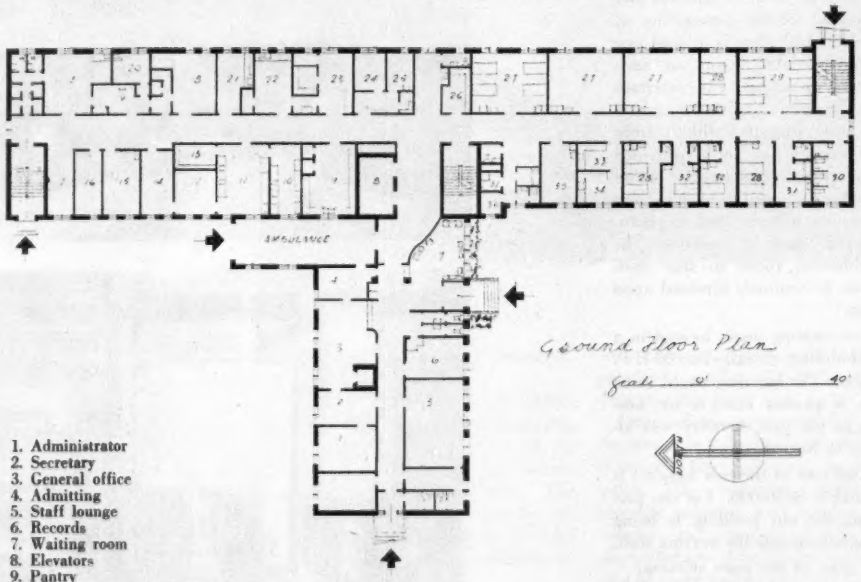




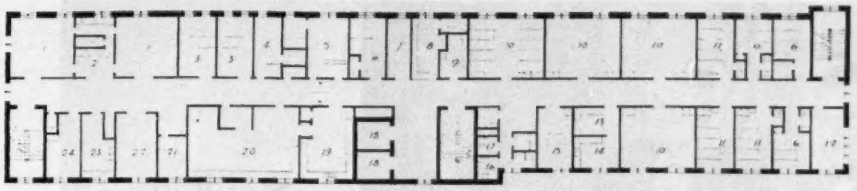
Above: a section of the laundry.
Centre: a corner of the haemotology room.
Below: some of the heavy cooking equipment in the kitchen block is fine.



1. Dining room
2. Formula
3. Diet. office
4. Dining room
5. Kitchen
6. Canteen
7. Elevators
8. Dishwashing area
9. Repair room
10. Receiving room
11. Transformer
12. Switchboard
13. Morgue
14. Classroom
15. Nurses' lounge
16. Nurses' lockers
17. Female lockers
18. Male lockers
19. Linen
20. Equipment room
21. Case & food storage
22. Furniture storage
23. Records
24. General storage



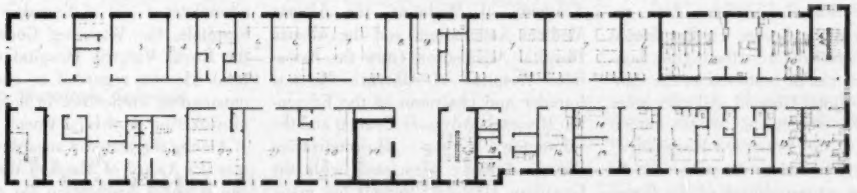
1. Administrator
2. Secretary
3. General office
4. Admitting
5. Staff lounge
6. Records
7. Waiting room
8. Elevators
9. Pantry
10. Washing and sterilizing
11. Laboratory
12. Haematology
13. Stores
14. B.M.R.
15. Radiology
16. Office and viewing
17. Dressing rooms
18. X-ray room
19. Storage
20. Dark room
21. Pharmacy
22. Cystoscopic
23. Fracture
24. Examining
25. Treatment
26. Linen
27. 4-bed ward
28. 2-bed ward
29. 6-crib ward
30. 4-crib ward
31. Sub-utility
32. Private ward
33. Clean utility
34. Soiled utility
35. Quiet room
36. Flower room
37. Janitor
38. Unassigned



Second Floor Plan

Scale 0 10

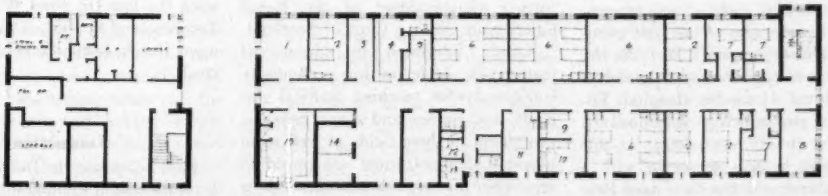
1. Operating
2. Scrub-up
3. Recovery
4. Nurses' lockers
5. Doctors' lockers
6. Private ward
7. Waiting
8. Nurses' station
9. Linen
10. 4-bed ward
11. 2-bed ward
12. Sitting room
13. Clean utility
14. Soiled utility
15. Quiet room
16. Flowers
17. Janitor
18. Elevator
19. Pantry
20. Central sterilizing
21. Surgical supplies
22. Minor operating
23. Clean-up
24. Anaesthesia



Third Floor Plan

Scale 0 10

1. Delivery
2. Scrub-up
3. Emergency delivery
4. Clean-up
5. Private ward
6. 2-bed ward
7. 4-bed ward
8. Waiting room
9. Nurses' station
10. Nursery
11. Nursery work room
12. Suspect nursery
13. Premature
14. Clean utility
15. Soiled utility
16. Quiet room
17. Flowers
18. Janitor
19. Elevators
20. Pantry
21. Work room
22. 3-bed ward
23. Doctors' lockers
24. Nurses' lockers
25. Labour room



Tent House Plan

Fourth Floor Plan

Scale 0 10

1. Treatment
2. 2-bed ward
3. Waiting room
4. Nurses' station
5. Linen
6. 4-bed ward
7. Private ward
8. Sitting room
9. Clean utility
10. Soiled utility
11. Quiet room
12. Janitor
13. Flower room
14. Elevators
15. Pantry

Stephens Memorial Award Presented

Dr. A. C. McGugan, right presents Dr. A. F. Anderson with the award citation and a small personal gift, as Dr. A. L. Swanson smiles approval.

ON October 17th, Dr. Andrew F. Anderson of Edmonton, Alta., received the George Findlay Stephens Memorial Award—the highest honour which can be bestowed by the Canadian Hospital Council. All eyes were upon Dr. Anderson, at the annual banquet of the Associated Hospitals of Alberta convention, as Dr. A. C. McGugan, vice-president of the Council, presented the award citation and a small personal gift.

This award, a tribute to the memory of the late Dr. George Findlay Stephens, was established in 1949 and is presented for noteworthy service in the field of hospital administration.

Although Dr. Anderson recently retired from active administration, he has long been a leader in the hospital field. Born in Campbellford, Ont., he studied at Trinity Medical College in Toronto and graduated from Manitoba Medical College, Winnipeg, in 1902. Dr. Anderson spent several years in practice and, when the University of Alberta Medical School was organized, he became one of the first members of the teaching staff. In 1928, Dr. Anderson was appointed superintendent of the Royal Alexandra Hospital, Edmonton, a post which he held until his retirement twenty years later. At this time, 1948, he was presented with a life membership in the Associated Hospitals of Alberta.

Dr. Anderson not only successfully piloted his hospital through the difficult thirties but also took a very active part in promoting the development of regional and national organizations. He is a past-president of the Edmonton Academy of Medicine, the Alberta Medical Association, and the Alberta Hospital Association (now the Associated Hospitals of Alberta). He was founder and chairman of the Edmonton Hospitals Advisory Council and the Edmonton Group Hospitalization Board. Actively associated with the Canadian Hospital Council for many years, he served as vice-president in 1944-45. He has been a Fellow of the American College of Hospital Administrators since its inception and was a member of the Board of Regents of that College for district 15. He is also a member of the American Hospital Association.

Notwithstanding his many duties, Dr. Anderson (known as "Andy" to his host of friends) found time to be one of Canada's foremost curlers. He is a charter member and past-president of the Royal Curling Club of Edmonton, past-president and life member of the Dominion Curling Association, and a former vice-president of the Royal Caledonian Curling Club of Scotland.

Keenly interested in educational matters, Dr. Anderson was particularly concerned with teaching medical students and nurses and many persons, prominent in these fields as well as in hospital administration, are proud to remember him as their preceptor. He is respected for his judgment, admired for his determination, and held in deep personal affection by his friends and colleagues.

The Award as a Memorial

Dr. George Findlay Stephens died in April, 1948. During his lifetime, he administered two of Canada's leading hospitals, the Winnipeg General and the Royal Victoria Hospital of Montreal. He was regarded as one of the outstanding authorities in hospital administration on this continent.

Among the honours accorded to him was the Award of Merit of the American Hospital Association. As president of that organization, as president of the Canadian Hospital Council, and in countless other offices of trust and responsibility, Dr. Stephens had a distinguished record.

No more fitting tribute to Dr. Stephens' memory could have been chosen, when establishing a Canadian meritorious award, than to name it the George Findlay Stephens Memorial Award. Each time an outstanding Canadian is honoured with the presentation of this award, Dr. Stephens is also honoured. The late Dr. A. K. Haywood of Vancouver was the first recipient of the award; in 1950, it was bestowed upon the late Dr. Fred W. Routley of Toronto; and in 1951, it was conferred upon Dr. A. Lorne C. Gilday of Montreal.

* * * *

Traduction

Le 17 octobre, le Docteur Andrew F. Anderson d'Edmonton, Alberta, se voyait décerner le Prix Commémoratif George Findlay Stephens—le plus grand honneur qui puisse accorder le Conseil des Hôpitaux du Canada. Il lui fut présenté par le Docteur A. C.

(Suite sur la page 106)

New executive, back row, left to right: S. V. Price, Calgary; William Chessor, Lacombe; Leonard Wilson, Drumheller; and L. R. Adshead, Edmonton (secretary-treasurer). Front row, left to right: Sister Mary Helen, Barrhead; Judge Nelles V. Buchanan, Q.C., Edmonton, (president); Dr. D. R. Easton, Edmonton, (vice-president); and H. P. Wright, Calgary.

Alberta Hospitals Convene

Program on Schedule

THE NINTH annual convention of the Associated Hospitals of Alberta got off to a flying start Thursday, October 16th, when Mayor D. H. MacKay of Calgary opened the sessions by welcoming the delegates to the city. The program continued to sweep along on schedule throughout most of the three-day period and the executive of the association are to be congratulated on a well-organized job. Reginald Adshead, secretary-treasurer, deserves special mention for his untiring efforts.

It was unfortunate that the limited space in the hotel, allotted to the convention, caused some congestion, by hampering the arrangements of the exhibitors' booths and making entrances and exits from the sessions somewhat difficult. The convention appears to be outgrowing the space assigned this year and will soon require additional accommodation for Alberta's vigorous and expanding program, as well as the many fine exhibits.

During the first morning, the association heard reports from the president, Leonard Wilson, Drumheller; from the secretary-treasurer and economics committee read by Mr. Adshead; from Blue Cross by the executive director, J. A. Monaghan; and from the president of the Associated Auxiliaries of the Hospitals of Alberta, Mrs. John Oliver.

The president, Mr. Wilson, laid a strong brief before the meeting in which the Alberta hospitals informed the provincial government that an increase in the basic ward rate must be recommended, effective as of January 1st, 1953, unless the government will reimburse hospitals for maternity and old age pension cases at cost, including the full cost of "extras". The "extra" charges, for special diets, x-rays, medicines, et cetera, are approved by the schedule of the Associated Hospitals of Alberta but are not fully covered, at present, by provincial plan payments. The brief likewise urged the establishment of a provincial government commission to investigate hospital costs and also to look into the many governmental and private hospital plans in an effort to lessen confusion in billing and collecting under different schemes.

In his report on the Alberta Blue Cross Plan, Mr. Monaghan was hopeful that the plan, which was on the verge of collapse a few years ago, was now achieving some stability. Previously operating at a deficit, the plan now has substantial cash reserves. Although these reserves are not yet sufficient, Mr. Monaghan believes that, with the continued support of the hospitals, satisfactory solvency to meet all contingencies is nearly within reach.

Mrs. John Oliver, in her report on the work of the provincial auxiliaries association, pressed for extension of auxiliary activity, particularly on the national level. She stated that, although the association did not have an attending delegate at the organizational meeting of the National Council of Hospital Auxiliaries of Canada, in Ottawa, May, 1951, an Alberta woman was appointed to the national executive and that future active participation was essential.

The afternoon session on the first day dealt with special problems affecting hospitals such as the maintenance of laundry equipment, treatment of water, oxygen supply systems, explosion hazards, air conditioning, and the

(Text continued on page 81)

At one of the well-attended

Pictured left to right are: Dr. A. L. Swanson, executive secretary, Canadian Hospital Council; Menzie M. Dyck, Calgary General Hospital; Mrs. T. L. O'Keefe, chairman of the board, Calgary General Hospital; Louis Protti, Edmonton General Hospital; and Paul K. Moreland, chairman of board, Raymond Municipal Hospital.

Among the Sisters attending convention are, left to right: Sister Marguerita and Sister Mary Michael, both from St. Michael's General Hospital, Lethbridge; Sister L. Noel, Holy Cross Hospital, Calgary; Mother M. Immaculata, Lethbridge; and Sister M. Roderick and Sister Rosalie Marie, both of Pincher Creek.

general sessions in Calgary

Murray Ross of the Canadian Hospital Council is seen (left) chatting with Sister Mary Helen, Barrhead, (new president of the Catholic Hospital Conference of Alberta); Florence Watkins, Taber Municipal Hospital; Sister M. Beatrice, Lethbridge; and T. E. James, Taber.

Enjoying a moment between sessions are, left to right: Ida Johnson, Royal Alexandra Hospital, Edmonton; Gertrude M. Hall, Calgary General Hospital; Jean MacPhee, Bentley Municipal Hospital; Elsie Lee, Battle River Hospital, Manning; and Mrs. Eleanor Bland, Calgary.

Saskatchewan to Hold Three-day Meetings

AT the Bessborough Hotel, Saskatoon, some 200 delegates from the 116 member hospitals registered for the thirty-fourth annual convention of the Saskatchewan Hospital Association, October 8th and 9th.

Following registration and the invocation by Rev. Father Henri Légaré, executive director of the Catholic Hospital Council of Canada, the delegates were welcomed to Saskatoon by Mayor J. S. Mills.

The Mayor who, coincidentally with this office, is also chairman of the board of the Saskatoon City Hospital, spoke of the need for narrowing the "gap" between total payments by the Saskatchewan Health Services Plan and total cost of hospital operation, citing figures from his own hospital to show that this gap was actually becoming greater. Mr. Mills also paid tribute to hospital trustees who render a public service on hospital boards which is too often unappreciated by the public at large.

Extending the best wishes of the medical profession, Dr. J. F. C. Anderson of the Saskatchewan College of Physicians and Surgeons, Saskatoon, called for full co-operation between doctors and hospitals. Dr. Anderson stated that the quality of hospital care and of medical practice in hospitals must be held at a high level and that standards must not be allowed to fall. He urged support of an accreditation program in which the Canadian Medical Association (of which Dr. Anderson is a past-president) has taken a leading role.

President H. H. Bassett of Prince Albert reviewed the main activities of the Association during the past year and dealt with several meetings which had taken place with representatives of the Saskatchewan Department of Public Health. He reported that the relationship between the two groups remained co-operative and that many improvements in the insurance service had been made. Further, he advised delegates of the recommendation by the executive that a full-time executive secretary be appointed and that such a step was approved by the rate board for purposes of membership assessment. High tribute was paid to the retiring secretary-treasurer, John Smith of Yorkton, for his many years of service (see page 48).

Mr Bassett reported that the association had increased in size, strength, and importance, and urged member hospitals to "keep up the good work". He extended thanks to E. V. Walshaw and J. C. Saunders of Saskatoon for taking care of the exhibits and making other local arrangements for the meeting; and he expressed gratitude to the executive for their splendid support and assistance throughout his term of office.

The official report of association work, presented in Regina a year previously, was approved following a motion to this effect by the secretary-treasurer, John Smith. Mr. Smith also gave the financial membership and other reports which were adopted by resolution. The association now represents 116 hospitals which have a total bed capacity of 5,491.

Hon. T. J. Bentley, provincial minister of public health, spoke on the progress being made in providing for the payment of hospital bills through the medium of insurance. He stated that

Newly-elected officers of the Saskatchewan Hospital Association are: Back row, left to right, Norman Hall, Shaunavon, executive member; H. B. Myers, Rosetown, president; John Smith, Yorkton, vice-president and interim secretary-treasurer; and S. N. Wynn, Yorkton, executive member. Front row, left to right: E. F. Bourassa, Regina, executive member; M. F. Kushnir, Canora, executive member; Dr. H. E. Baird, Regina, executive member; and H. H. Bassett, Prince Albert, immediate past president.

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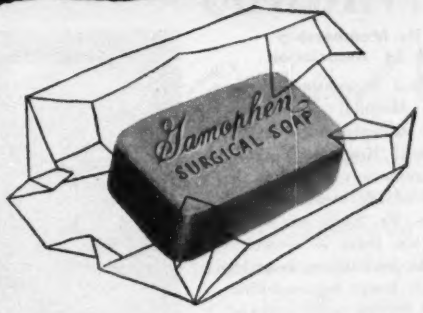

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the eyes of all Canada and of many other countries were following with deepest interest the experiments in health care being carried out in Saskatchewan. He paid tribute to the work and constructive criticism which came from the association, classing it as one of the most important in the province.

Rehabilitation and care of the aged was declared by Hon. J. H. Sturdy, minister of social welfare and rehabilitation, to be Saskatchewan's "most rapidly accelerating" problem. Outlining what had been accomplished to date, Mr. Sturdy went on to enumerate many other projects now in the planning stages, including a 300-bed unit which will be associated with the new university hospital to serve both as a treatment and research centre.

Dr. George W. Peacock, registrar, Saskatchewan College of Physicians and Surgeons, spoke on the contributions made by citizens in various walks of life who serve as hospital board members. "The Problems of Small Hospitals", a perennial topic, received a new treatment by J. A. Vopni, secretary, Davidson Union Hospital, Davidson. He suggested that many of Saskatchewan's 108 hospitals of 25 beds or less might well be closed and local effort and money directed to fewer but improved community institutions. His theme might have been entitled "The problem of the small hospital is the unnecessary number of small hospitals".

Dr. Owen C. Trainor of Winnipeg, president of the Canadian Hospital Council, spoke on some aspects of the council's work and emphasized the need and usefulness of hospital organizations at local, regional, provincial, and national levels. The council's associate secretary, Murray Ross discussed "Human and Public Relations".

The Canadian Hospital Accounting Manual was described by Robert M. Clements of the Department of the Public Health, Regina. Having acted as technical director in the preparation of the manual for the Canadian Hospital Council, Mr. Clements' address was technically sound and delivered in an easy manner which made it understandable to all his listeners. A lively discussion period followed with G. W. Meyers, executive director, Saskatchewan Health Services Plan, James E. Robinson, department of Public Health, Regina, Dr. G. W. Peacock, H. H. Bassett, Norman Hall, Shaunavon, and many others contributing.

The annual convention dinner was well attended and H. H. Bassett presided. Dr. Gordon E. Wride, associate director of health insurance studies, Department of National Health and Welfare, Ottawa, was guest speaker. A former official of the Saskatchewan Health Services Planning Commission, Dr. Wride expressed personal thanks for the experience he had gained and the knowledge and information which had been passed on to him by the administrators and trustees of the hospitals of the province. In this interesting address, Dr. Wride reviewed the progress in health care in Canada, generally, and in Saskatchewan particularly. He held out great promise for more and better things to come if Canadians maintained their interest and enthusiasm for progress in matters pertaining to health.

On the second day many more visitors than usual attended the convention and the sessions were presented to larger and even more enthusiastic audiences than ever before.

With only two days for meetings, addresses on the program were limited to twenty or thirty minutes. However, most speakers found it difficult to keep within these bounds and, as a consequence, many discussion periods were greatly shortened or eliminated entirely in an effort to keep the program on schedule. There was strong feeling among delegates that a three-day meeting was necessary to allow more time for both the addresses and discussion periods and it was voted to extend future meetings to three days at the discretion of the executive. Although the concurrence of the Western Canada Institute with the 1953 Saskatchewan Hospital Association meeting will probably render it impractical to hold a longer meeting next year, the ground has been laid for three-day meetings in the future. This is good in that it reflects the growing interest and expanding activity of the Saskatchewan group.

During the second morning, Dr. F. B. Roth, deputy minister of public health for Saskatchewan, outlined a plan whereby student laboratory technicians will be enrolled for eleven months at Regina College for scientific training. Following the college period, students will spend twelve months in practical application of their work in various hospitals in the province before receiving their diplomas. Dr. Roth believes that this new form of training will result in more uniformly and better trained technicians. He also stressed

(Concluded on page 102)

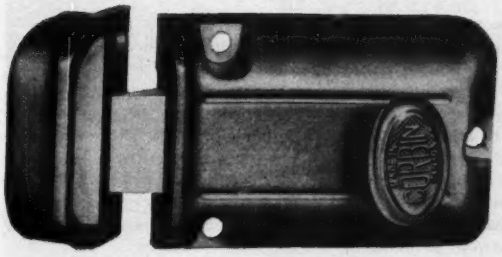
First Life Membership Awarded by Association

At the annual convention of the Saskatchewan Hospital Association, John Smith, administrator of the Yorkton General Hospital, Yorkton, Sask., was unanimously elected as the first recipient of life membership in the association. Mr. Smith has served for the past ten years as secretary-treasurer of the association, assuming the increasingly heavy responsibilities as a personal service while carrying out his hospital administrative duties at Yorkton.

With the steadily expanding growth of the association, which has been due, in a large measure, to Mr. Smith's capable guidance and unselfish devotion, a full-time executive officer has been required for some time. The new position was established at this year's meeting and a full-time executive secretary will be selected as soon as possible.

Although Mr. Smith's resignation was accepted with deep regret he has

graciously consented to carry on the duties of this office until the new full-time appointment is made. He will continue to be connected closely with association affairs as the in-coming vice-president of the Saskatchewan Hospital Association. ●



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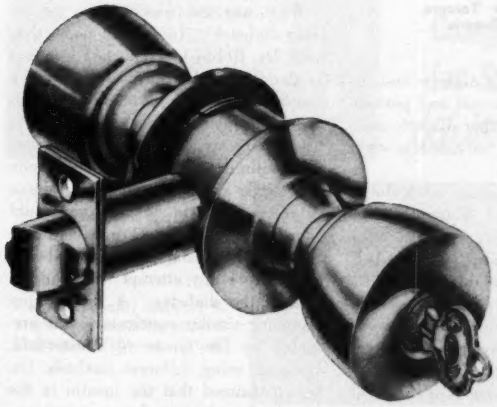

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Diabetics Convene in Holland

Gerald A. Wrenshall, Ph.D.,
Member of Research Staff,
Banting Institute,
University of Toronto,
Toronto, Ontario.

DURING the past summer, I was a delegate from the Diabetic Association of Ontario to the first congress of the International Diabetes Federation held in Holland. In that capacity, I attempted to act as eyes and ears for the association not only during this week-long conference but also at all other times, since events of interest to persons with diabetes occurred throughout the trip.

I shall try to answer the following questions:

(a) What were the highlights of the I.D.F. Congress?

(b) In what ways did Canada and Canadians contribute to the Congress?

(c) What personal experiences, travelling as a diabetic, are of general interest to other diabetics?

Highlights of the Congress

First of all, I must say a word concerning the plan of the meetings. Medical and lay delegates from the fourteen national member associations resided in hotels at Noordwijk on the North Sea coast of Holland during the week of the conference; and were transported inland daily by bus to Leiden for most of the meetings. A few of the meetings included all representatives, the balance being subdivided into sessions in which problems of diabetes of medical and scientific interest were presented and discussed and sessions in which the social and economic problems of the diabetic were considered. For wives of the delegates and others not attending the aforementioned sessions there were tours and social events, all managed very efficiently by the I.D.F. executive and the Dutch Diabetic Association, who treated us during our stay as honoured guests.

Throughout the conference week exhibits from various member diabetic associations were on display. Outstanding among these were the displays of the Swedish, Danish, and Netherland Diabetic Associations, showing pictures of the summer camp activities, statistics on membership, and illustrations and tags used in recruitment and financial campaigns. Canada was one of seven countries to present such an exhibit. In addition to diabetic associations, various producers of food preparations for diabetics exhibited their wares in the same room.

Of particular interest to us, as a young and expanding diabetic association, were the occasional and periodical publications of other diabetic associations which they included in their exhibits.

During the conference week forty-nine scientific and sixteen socio-economic papers were read, in addition to several sessions of the I.D.F. Council and innumerable private discussions. Another twenty-two scientific papers were presented and discussed in a second smaller conference on diabetes held during the following week, which I was permitted to attend. From the many interesting topics discussed, I have selected for special comment one or two which I felt were of immediate and direct interest to diabetics.

One interesting report originated in Germany. Dr. Bernhardt, chief of the Diabetes Centre of the Berlin Insurance Institute, described to us how about 8,000 diabetics insured by this company can get their insulin only through application at the Centre and hence were under frequent and regular observation. She reported that prior to the blockade of Berlin many of the adult diabetics were fat. During the months of blockade when the supply of food in Berlin was very limited these diabetics could not obtain food in the quantities to which they had become accustomed and their body weights were reduced appreciably. In a majority of these subjects, Dr. Bernhardt reported that diabetes disappeared at the same time. With the lifting of the blockade, many of these people again increased their food intake sufficiently to become obese once more and their diabetes reappeared (reminiscent of Newburgh and Conn's findings in the U.S.A. a decade ago that more than three out of four obese American diabetics, in their clinic, who reduced their body weight to normal regained normal fasting blood sugar and showed normal tolerance for glucose, all without the use of injected insulin).

What was the cause of this release from diabetes? In another paper diabetic Dr. Robin Lawrence, of London, England, provided an answer. With a special technique, developed by an Australian named Dr. Bornstein, these medical scientists were able to measure the insulin in the blood of non- diabetic and newly diagnosed diabetic human subjects. They found that they could characteristically detect insulin in the blood of middle-aged obese diabetics even before any attempt was made to control the diabetes. A third paper reporting similar conclusions was presented by Dr. Groen of Amsterdam, Holland, using different methods. Dr. Groen claimed that the insulin in the blood of such diabetics was quite as high as non-diabetic subjects of normal weight.

What is the significance of these reports to us as diabetics? It is becoming clear that a majority of obese diabetics have a good supply of insulin produced by their own pancreas and can become clinically non-diabetic simply by re-

A report to the Diabetic Association of Ontario on the Congress of the International Diabetes Federation held in July, 1952, at Leiden, Holland. The author is a diabetic and chairman of research for the D.A.O.

ducing body weight to or below normal and keeping it there by sustained restriction of food intake. Failure to effect this reduction in body weight exposes them to the many degenerative changes of blood vessels, kidneys, eyes and so on, which are associated with the undetected or uncontrolled diabetic state. Since diabetes in the middle-aged fat person is the type most frequently observed, the above reports indicate that an excellent way exists for many diabetic persons to improve their condition immensely if they have the necessary strength of mind to reduce their weight to normal by proper dietary restriction.

According to Dr. Lawrence, the above situation has not been found to hold for young diabetics or for diabetics of any age who are subject to ketosis when their diabetes is not under control. Such diabetics are almost completely dependent on injected insulin to control their diabetes. I myself am such a diabetic.

I cannot leave the topic of conference highlights without remarking on the sense of community which developed among the delegates and others in attendance at the first I.D.F. Congress. Interestingly enough, this sense of community had its first roots in the problems of diabetes—showing that it is an ill wind that blows nobody good. However, topics of private discussion quickly broadened out with comparisons of ways of life and interests in the different countries represented. My wife and I left with the feeling that many new ties of international friendship and understanding had been made at the conference. In these days of international tension it is good to feel that diabetes has served to bring people of many nations closer together.

Contributions by Canadians

Our honorary president, Dr. Charles Best, is also the honorary president of the I.D.F., and he presented the inaugural address at the University of Leiden in which he surveyed the present status of medical research on diabetes mellitus. Dr. Best also gave the opening address at the symposium on experimental diabetes which took place in Leiden under the joint auspices of UNESCO and WHO, during the week following the I.D.F. Congress. This time his subject was "The Islands of Langerhans" and the paper, while quite comprehensible to the lay diabetic, afforded an excellent historical perspective to the scientific personnel gathered from all parts of the "free" world for the conference. Sometimes I feel that we as Canadian diabetics are insufficiently aware of our good fortune in having Dr. Best, the co-discoverer of insulin, with us here, acting both as a guide and as a very true friend.

Dr. J. Campbell presented a paper at the second conference entitled "Growth Hormone and Protein Metabolism", dealing with new findings by his research group in the Department of Physiology, University of Toronto, concerning diabetes produced in dogs by growth hormones.

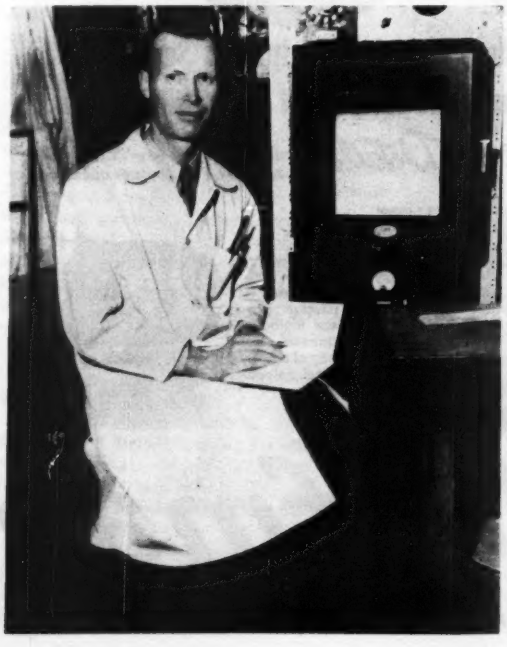
I could list the contributions of several other scientists at the conference who have lived or worked for a time in Canada. However, these cannot be considered as truly Canadian contributions. An interesting example was the chance discovery that Dr. F. N. Allan, this year's president of the American Diabetes Association, was born in Ontario.

I have already mentioned the Canadian exhibit at the I.D.F. In addition, I had the honour of presenting two papers as a delegate of the D.A.O. The first of these was a scientific report on "Acetone in Human Breath", an account of the findings from the D.A.O.'s first research project in which the members of a diabetic association participated as volunteers.

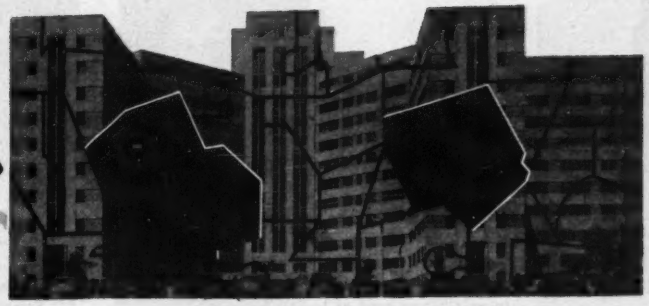
The second report was to the lay diabetic group and was entitled "The D.A.O. as the First Organization of Lay Diabetics in Canada". The Association was described under four headings: (1) How did the D.A.O. come into being? (2) For what purposes was it organized? (3) What progress has been made toward fulfilling these purposes? (4) What does the future hold in prospect for the D.A.O.?

Each of us as a diabetic develops certain ways of meeting the daily problems involving food, insulin, and exercise, which arise in a more or less regular sequence throughout daily activities. For a diabetic travelling over unfamiliar territory, the regular sequence is frequently disorganized, sometimes in unusual ways, and the diabetic should try to anticipate such situations before they arise. He can and should, of course, carry a supply of insulin more than sufficient for his needs during the entire trip and a spare syringe kit carried separately from the regularly used one. He should be equipped to make tests of urine for sugar and acetone bodies, and should use this equipment regularly. He

(Concluded on page 116)



The author at work.



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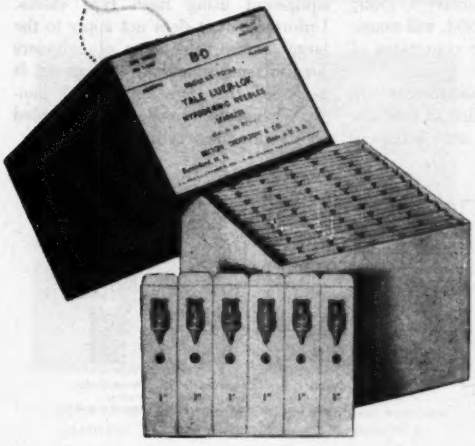

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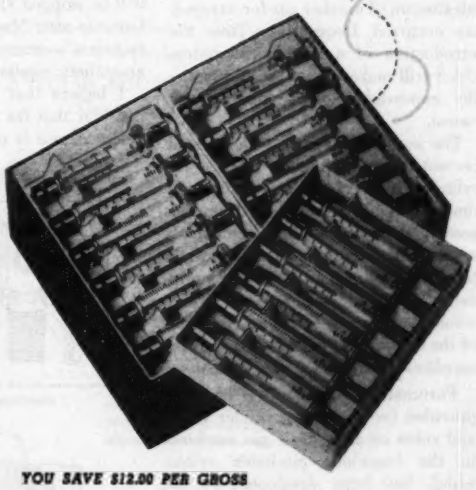

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On the left is the yoke with adapter installed and, on the right, is a cylinder valve correspondingly drilled.

In administering medical gases

Pins Can Save Lives

R. A. Gordon, M.D., F.R.C.P. (C), F.A.C.A.,
Secretary-Treasurer, Canadian Anaesthetists Society, Toronto

THE INTRODUCTION of any equipment which increases the safety factor in the administration of anaesthetics must be welcomed by all professional anaesthetists. The accidental transposition of gas cylinders to incorrect positions on the anaesthetic machine (and, especially, the substitution of another gas for oxygen) has occurred frequently. Thus the introduction of a mechanical system which will make such mishaps practically impossible must be doubly welcomed.

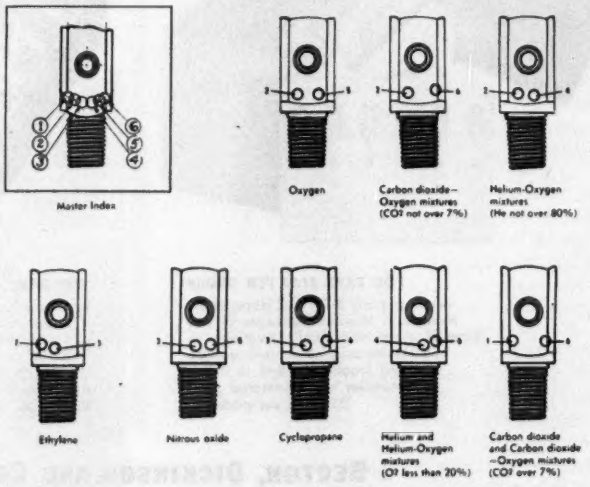
The need for a system which would prevent the interchange of medical gas cylinders has been recognized for some time and many methods have been suggested. However, to be acceptable, a system had to be devised which would be easily applicable to existing equipment and, furthermore, one which would be practical from the viewpoint of the compressed gas industry and the suppliers of anaesthetic equipment.

Fortunately, such a system has been provided for flush-type cylinder valves and yokes on anaesthetic gas machines in the ingenious pin-index system which has been developed by the American Compressed Gas Association in consultation with the American Hospital Association, and the American Society of Anesthesiologists. This system is based on the use of pins in the yoke of the anaesthetic machine which match holes in the valve of the gas cylinder. Six standard positions are assigned for the pins and holes with a combination of two of these positions being assigned to each of eight gases and gas mixtures. The eight gases and gas mixtures now provided for in the system are: oxygen, oxygen-carbon dioxide mixtures; oxygen-helium mixtures (80 per cent or less of helium); ethylene; nitrous oxide; cyclopropane; helium; and carbon dioxide.

The Compressed Gas Association have worked out a time-table for the conversion of cylinder valves and equipment to this pin-index system in order to avoid the confusion which might arise if equipment were converted before all cylinder valves had been drilled with the appropriate holes. Thus, it will be impossible to use an undrilled cylinder in a "converted" yoke, although drilled cylinder valves will still fit yokes to which pins have not been added. According to the time-table, no more undrilled cylinders will be shipped after January 1, 1953; but only after May 1, 1953, will manufacturers commence the conversion of anaesthetic equipment.

I believe that all anaesthetists will consider that the adoption of this new safety device is of the utmost importance. Since it appears that this system is to be standard on all new anaesthetic gas equipment and that conversion of existing equipment is possible at a relatively low cost, it might well be that failure to provide this safety device on anaesthetic equipment could be construed in a court of law as failure to take "due and reasonable care". The success of this system in preventing future accidents with anaestheic gases will depend ultimately on the co-operation of hospitals in carrying out the conversion of existing equipment.

The pin-index system applies only to equipment using flush type valves. Unfortunately it does not apply to the larger screw valve type of cylinders used in some anaesthetic equipment. It is hoped that some system of non-interchangeability may be provided shortly for these cylinders.



Pictured above are the eight assigned combinations of holes in the cylinder valve bodies and the master index. Numbers indicate the standard designation for each hole.

A typical infantile paralysis case with right quadriceps weakness. Courtesy of The Strong Memorial Hospital, Rochester, N. Y.

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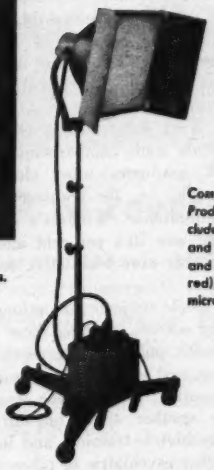

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Demonstration School of Nursing, Windsor, Ont.

The Two-year Plan Evaluated

A. R. Lord, LL.D.,
Vancouver, B.C.

A DETAILED report, issued in June, 1952, by a joint committee of the Canadian Education Association and the Canadian Nurses' Association, has found that nurses can be trained at least as satisfactorily in two years as in the usual three years but only if some new source of revenue can be secured. In such a scheme hospitals would be used to provide only enough clinical experience for training purposes; more graduate nurses and other paid personnel would be required; and a larger part of the cost of nursing services would be paid for in money instead of in student services. On the other hand, a shorter course and much better conditions of training might be expected to increase the supply of nurses.

An experimental two-year "Demonstration School of Nursing" has been in operation since January, 1948, in Windsor, Ontario, under the supervision of the Canadian Nurses' Association and financed by the Canadian Red Cross Society for a four-year period. As an independent school, it had its own board of directors and was associated with the Metropolitan Hospital for clinical practice. With the end of the experiment in October, an evaluation was a necessity and this was arranged through the co-operation of the Canadian Education Association.

The joint committee included: Dr. J. G. Althouse, chief director of education, Ontario; Sister Denise Lefebvre, Institut Marguerite d'Youville; Evelyn Mallory, director, school of nursing, University of British Columbia; Allan McCallum, deputy minister of education, Saskatchewan; Agnes Macleod, director of nursing, Treatment Services, Department of Veterans' Affairs; Dr. A. J. Phillips, National Cancer Institute of Canada; Miss E. K. Russell, director, School of Nursing, University of Toronto, Helen McArthur and Gertrude Hall (president and general secretary, Canadian Nurses' Association); Dr. H. P. Moffat and F. K. Stewart (president and executive secretary, Canadian Education Association). Dr. A. R. Lord, Vancouver, was named director of evaluation.

The absence of any considerable uniformity in the programs required by hospital schools of nursing and of any generally accepted criteria for measurement made two steps necessary in this evaluation. All relevant information was first secured concerning the Windsor school, followed by similar data for three "control" hospital three-year schools and comparisons were drawn. Two "control" schools were in large Ontario cities, one was in Saskatchewan, and all were highly recommended by provincial authorities.

Between admission and graduation the Windsor school lost nine per cent of its students and the "control" schools lost between 21 to 30 per cent. The reasons were: at Windsor — unsuitability; "control" schools — dislike of nursing, unsuitability, ill health. Absences, because of illness, were fewer in Windsor and available time for study and for recreation was much greater.

Wide differences in content of curricula made comparisons difficult but all graduates must clear one last hurdle, *i.e.*, the registered nurses' examinations. Windsor's over-all average was 76.4 per cent and "control" schools were 69.7, 70.5, and 70.7 per cent.

Some subjects are optional for nursing schools. Among these are mental health, public health, psychiatric nursing, and tuberculosis nursing. In one "control" school none was available, in another about one-third received psychiatric training, and in the third, either psychiatric or tuberculosis nursing could be taken. In Windsor, all four subjects were compulsory and the use of mental health and public health principles in all phases of nursing was a significant aspect of the program.

Clinical experience is, of course, the most important part of a nurse's training. Supervision and repetition must make this thorough and it must deal with a wide variety of medical conditions and surgical procedures. More important still is the degree of integration which is provided between theoretical instruction and practice. The report points out two reasons why these aims were much more easily realized in Windsor than in three-year schools. The latter must give first consideration to the nursing needs of the hospital while the former is concerned first with providing the right type of practice. Also, Windsor had two classes to schedule at any time while "control" schools always had six, thus providing a problem which was impossible of solution.

All students in Windsor received the same amount of experience in each major clinical field and, very largely, the same types within each field. Practice was carried out under constant and thorough supervision and was so closely integrated with theory that the two were seldom more than a day or two apart. All "control" students received about the same total amount of practice but there were wide variations, sometimes more than 50 per cent, within each clinical field. Supervision was excellent but theory and practice, despite considerable effort, were usually separated by several weeks and were even sometimes in different years.

The cost per year of training a student is about the same in each type of school — roughly $1,300. Hence each "control" school three-year graduate costs about $1,300 more than a two-year Windsor product. Payment is a different matter. In "control" schools, students paid more than 75 per cent of these costs with their services and the hospital's "paying patients" met the rest. In Windsor, students paid $50 per year in cash, probably $340 in services and the Red Cross grant provided the balance.

The joint committee has issued its report as a purely factual statement of the development and program of the Windsor experiment but, because of the influence the school may have on nursing education, has added certain conclusions which have been reached. These include:

1. The average graduate of the Demonstration School, compared with

(Concluded on page 116)

Reprinted from "The Canadian Nurse", September, 1952.

What Do Hospitals Want Most in an Adhesive Plaster?

(The Results of a Survey Among 1,007 Leading Hospitals)

● Write for a FREE spool of Pro-Cap. Prove Pro-Cap to yourself on each of these 5 points. Make the patch test for skin irritation. You'll never go back to ordinary plaster.

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1877 75th 1952

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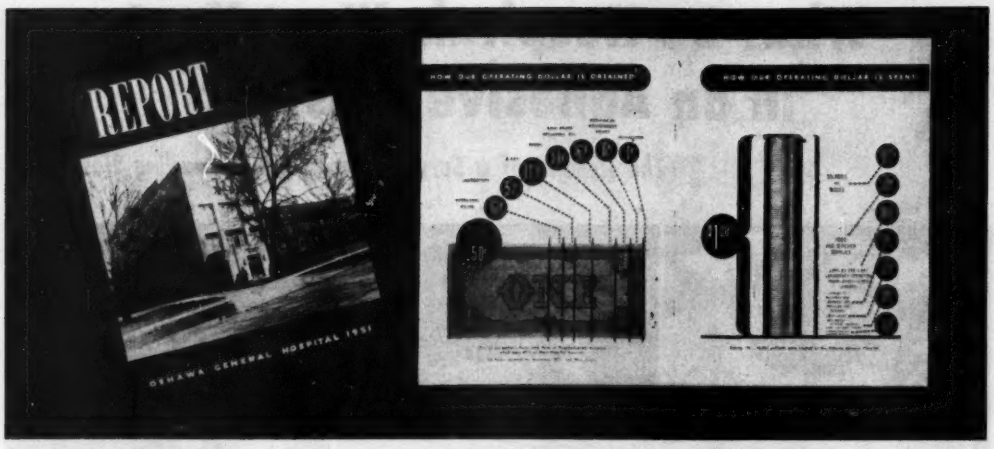
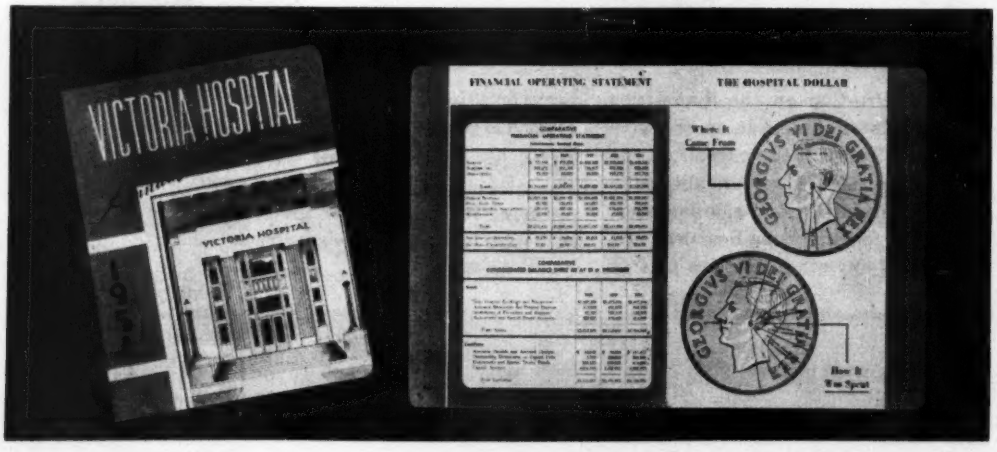


Canadian Winners in Annual Report Competition

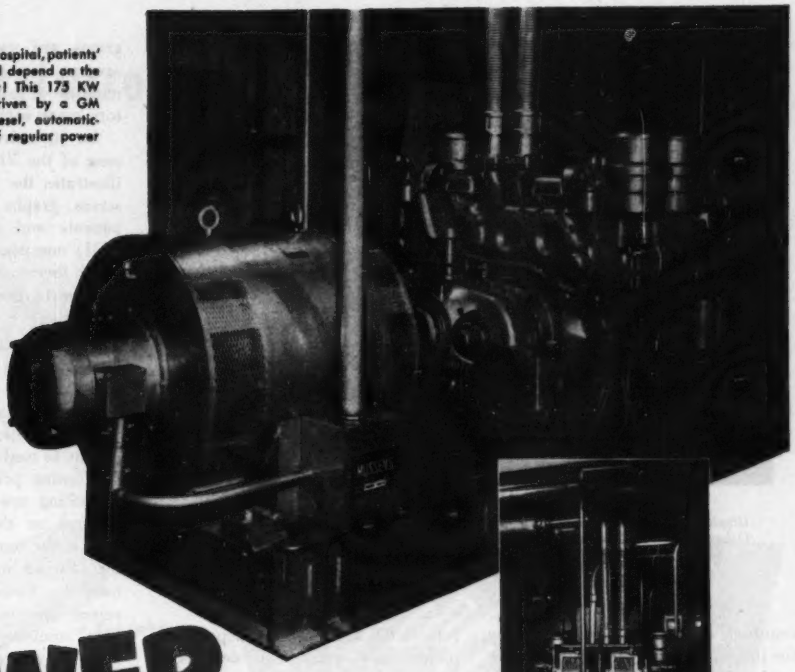
AN ENCOURAGING and well deserved recognition comes to hospitals each year for excellence in public relations programs and annual reports, through a contest sponsored by *Hospital Management* magazine. This year, three Canadian hospitals were honoured at the awards meeting held on Sept. 14th, in Philadelphia, Pa., for their annual reports. The Oshawa General Hospital, Oshawa, Ont., won first place in the "under 200 beds" group; the Victoria Hospital, London, Ont., placed first in the "over 400 beds" group; and the Vancouver General Hospital, Vancouver, B.C., was awarded an honourable mention certificate.

In judging the public relations programs, the judges set up certain general principles. First, an entry had to demonstrate a planned effort, not isolated incidents or accidental publicity. Secondly, the tone of the program had to be consistent with hospital tradition, that is, not straight advertising. Thirdly, the method of presentation was considered a basic factor, and was judged for its apparent sincerity, novelty, and attention-arresting qualities.

In the annual reports division, the judges looked for a condensed financial report, preferably presented with pictures or graphs. Not necessarily impressed by an annual report which had



In a modern hospital, patients' lives may well depend on the power supply! This 175 KW generator, driven by a GM Series 71 Diesel, automatically cuts in if regular power supply fails.



POWER on the spot

This picture of the stand-by power room at the Victoria General Hospital, Fredericton, N.B., illustrates the space-saving compactness of the GM 2-cycle Diesel. Parts are light in weight and easily accessible.

When you're on the spot for power, here's power on the spot!

In less than five seconds from the time of a power failure, this emergency generator delivers a full load of power to the Victoria General Hospital in Fredericton, N.B. Installed over a year ago, the stand-by generator is driven by a General Motors Twin Six Series 71 Diesel Engine.

Hospital authorities chose a GM Diesel for this vital task because of its all-'round operating superiority. Another important consideration is that Diesel fuel is less volatile and therefore greatly reduces fire hazard.

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Vulcan Machinery & Equipment Co. Ltd., 371 Sutherland Ave. ..... WINNIPEG, Man.
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Displaying their awards are, left to right: Miss M. Bourne, superintendent, Oshawa General Hospital, Miss Nellie G. Brown, recently retired superintendent of Ball Memorial Hospital, Muncie, Ind., and W. N. Roberts, assistant superintendent, Victoria Hospital, London.

required a large amount of money, the judges scanned entries for effectiveness in doing the job intended.

The three winning Canadian reports all exhibit effective devices. Colour, attractive layout, pictures, graphs, and illustrations, brighten their pages and help to tell an interesting story. Written descriptions are brief but informative. Besides displaying statistics, the reports tell about various departments, picture new equipment, demonstrate various teaching facilities, and show new construction.

Statistics are particularly well presented in the Oshawa General Report. With the use of illustrations of a dollar bill and a stack of coins, the report shows how the operating dollar is obtained and how it is spent. Small diagrams are used to demonstrate an average day at the hospital, *i.e.* the number of patients, operations, visitors, meals served, et cetera.

An attractive map near the beginning of the Victoria Hospital's report illustrates the large area the hospital serves; graphs show the number of in-patients and out-patients treated in 1951; one page is devoted to the new cobalt therapy unit at the hospital; and another to pictures of the highlights of 1951.

Besides statistics, the Vancouver General report has an interesting series of pictures and text describing the various hospital departments from admitting to education, electroencephalography to medical social service.

Winning prizes for annual reports is nothing new for either the Oshawa General or the Vancouver General. This is the fourth consecutive win for the Oshawa hospital and the second time the Vancouver General has received an honourable mention in "hm" contests.

At the awards meeting, speakers included, Dr. J. R. McGibony, medical director and chief of the Division of Medical and Hospital Resources, and Dr. Malcolm T. MacEachern. While winners modestly explained why they won, it was also emphasized that the time to start preparing for the 1953 competition is now.

Care of Cut Flowers

1. Recent discoveries of floral researchers show that tepid water (between 90 and 100 degrees) is better for roses, carnations, snapdragons, and spring flowers and that they tend to remain fresh longer than if placed in cold water.

2. Put these flowers deeply in warm water in a cool place for an hour or two before arranging them.

3. Cut the stem diagonally with a sharp knife; not with scissors as they may crush the little water channels in the stems and decrease the water intake.

4. Cut the bulbous flowers — daffodils, tulips, irises — above the white base of the stem.

5. Woody stems, including lilacs, stock, chrysanthemums, and roses, should have a special type of stem treatment to enable them to absorb water. Roses and stock may be scraped with a sharp knife from three to five inches up from the bottom of the stem so as to expose more cut surface for the intake of water. The hardest stems, such as lilacs and chrysanthemums, should be crushed slightly with a hammer or something heavy to expose the cells to water.

6. Bleeding stems, such as poinsettias, poppies, zinnias, and any stem which excretes a sticky substance, should be seared over a flame for about five seconds.

7. Always avoid placing flowers on top of each other when arranging them, as flowers bruise easily.

8. When using spike flowers, such as snapdragons, delphiniums, and gladioli, cut off the bud tip and the rest of the flower will last longer.

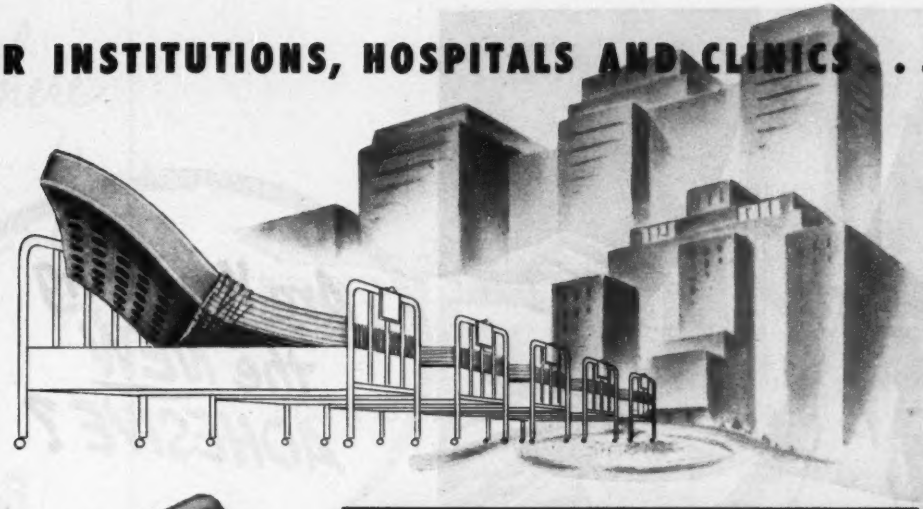
9. Always remove foliage below the water level to prevent its decaying and shortening the life of the arrangement.

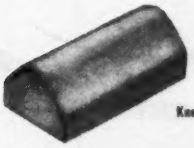
10. To treat magnolia leaves to turn them from their green colour to lovely bronze for use in autumn arrangements, place the stems in a solution of glycerin and water—using two parts of water to one part of glycerin. After about two weeks in the solution, the leaves begin to change colour. When they are the tone of bronze preferred, remove them from the solution. Then they may be combined with fresh flowers in water or with dried flowers without water.

11. Add a commercial flower preservative to the water of the flower arrangement, then it is not necessary to change the water every day.

12. Cut flowers should not be placed in direct heat or drafts. It is also a good idea to keep cut flowers away from direct sunshine. — *Society of American Florists*

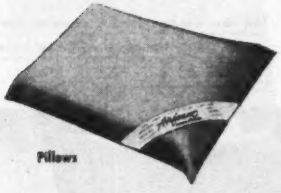
FOR INSTITUTIONS, HOSPITALS AND CLINICS . . .





Knee Cushions

Invalid Rings



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Harold Emerson Baird

WITH sadness and a deep sense of loss, we record the sudden passing on November 4th of Dr. Harold Baird, Regina.

Born, and now buried, near Chipman, New Brunswick, Harold Baird received his early education in his native province and in Alberta. He was graduated in medicine from Dalhousie University in 1927 and, after post-graduate training, he practised in New Brunswick until shortly after the outbreak of war. Discharged from the Royal Canadian Army Medical Corps as a Lieutenant-Colonel in 1946, after a distinguished military career, Dr. Baird accepted the superintendency of the Regina General Hospital. During his tenure of office, the hospital expanded its services and treatment facilities, and increased in size to over 800 beds and bassinets.

As a member of its executive committee, and, later, for two terms as its president, Dr. Baird served the Saskatchewan Hospital Association, during a period of change and uncertainty, with loyalty and wisdom. He was chairman of the Hospitals Committee of the College of Physicians and Surgeons of Saskatchewan and a member of the Health Survey Committee of that province. He was a member of the American College of Hospital Administrators, a member of the House Delegates of the American Hospital Association, and in 1951 was elected to the Board of Directors of the Canadian Hospital Council.

Of quiet and serious mien, Dr. Baird was nonetheless possessed of a keen sense of humour. His friendly personality gained for him the affection of a host of friends, even as his ability and integrity gained for him the highest respect of his associates.

The hospital field in Saskatchewan and in all of Canada has lost one of its staunchest friends and wisest counsellors. To Mrs. Baird and the members of his family we express our deepest sympathy. —*M.W.R.*

For anything worth having, one must pay the price; and the price is always work, patience, love, self-sacrifice — no paper currency, no promises to pay, but the gold of real service. — *John Burroughs*

CONSIDER THESE POINTS WHENEVER YOU BUY *Hypodermic* NEEDLES

A fine quality needle safeguards your patients against deep infection, often caused by burrs of metal, chips and abrasives left on ordinary needles. Bishop "Blue Label" Needles provide **maximum safety** because . . .

1 **Tougher Steel Resists Breakage.** 18-8 stainless steel is inherently tough. Bishop intensifies this quality by exacting metallurgical control and special manufacturing processes. Furthermore, the corrosion-resisting properties of 18-8 stainless steel are not merely skin deep, but are inherent throughout its cross-section.

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3 **The Precision Hub is Chrome-Plated**—and conforms to government specifications. Here, Bishop precision manufacturing experience helps again. Because the taper is accurately machined, Bishop Luer needles fit syringe tips closer, minimize syringe tip breakage and leakage.

4 **Continuous Inspection Insures Cleanliness.** To insure uniformity, cleanliness and finish, expert inspections, including hydrostatic pressure and microscopic tests are made at ten vital stages of manufacturing, thus eliminating any possibility of infection through burrs, chips and abrasives.

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Importance of forms which will provide maximum protection—

Consents for Operations and Anaesthetics

S. W. G. Ratcliff, M.B., Ch.M., F.I.H.A., F.I.H.S.,
Melbourne, Australia

ALMOST important and significant legal action was heard before Lord Justice Singleton in the King's Bench Division, England, in June last year.

A Folkestone (England) antique dealer suffered from hernia and, at the end of 1947, his general practitioner advised him to consult Dr. H. W. L. M., senior surgeon at the Royal Victoria Hospital, Folkestone. He did this and was admitted to the hospital and operated on in March, 1948, with complete success, by the house surgeon, Dr. L. P. R., not by the senior surgeon. When he discovered this fact he took the view that he had been wrongfully treated and brought an action against the senior surgeon for breach of an alleged oral agreement and for procuring a trespass upon him by the house surgeon. He did not sue the house surgeon.

The plaintiff gave evidence supporting his allegation that the senior surgeon had orally agreed to operate, of his admission to a public ward, of his suspicion after operation that it had not been carried out by Dr. M., of the confirmation of his suspicions, and of his "shock, worry and anxiety" that "an apprentice had practised his skill upon him without his consent."

The senior surgeon, in evidence, said that the house surgeon had been trained at Guy's Hospital and was a very able young man, that he made it quite clear that plaintiff would be admitted to a public ward at the hospital, that he had undertaken no personal obligation to the patient and, that on the day before the operation and near the patient's bed, he had told the house surgeon, in an ordinary tone, "you will do this one."

The Lord Justice, in giving judgment, remarked that the patient had had the benefit of a highly successful operation by a competent surgeon. Accepting the evidence of the senior surgeon against that of the plaintiff he found that there had been no breach of contract by Dr. M. to perform the operation. The latter was a man of honour and a witness of truth, but probably had not realized on the day before the operation that the patient expected him to perform it. The patient's right to choose his surgeon had not been challenged. On the other hand the house surgeon had operated without the patient's "consent, leave or licence" and the form of consent to the operation which the patient had signed "did not bar his right to bring an action for trespass". "For an unauthorized person to do this, even in a highly competent manner, an act that another was authorized to do, was a highly technical form of trespass for which the plaintiff would be awarded the nominal damages of £1." The consequences would have been much more serious if the evidence of the senior surgeon had not been accepted or if the operation had not been successful.

This case is of the utmost importance to hospital administrators in Australia, as it involves a review of the forms of consent now in use with particular regard to the fact that it is common practice for honorary surgeons to arrange for operations on patients admitted to public wards under their names to be performed by their honorary assistants or by members of the resident medical staff, such as surgical registrars and house surgeons. At times the operations so arranged are carried out quite independently of the honorary surgeon and at other times under his personal supervision. The practice is almost traditional, affording more junior surgeons the opportunity of gaining experience. Since the introduction of the practice of forming surgical units or teams in hospitals, it is usual for the senior surgeon to allocate appropriate cases to members of the team or unit. Both factors are in the public interest, especially in the case of medical practitioners who take up practice in rural districts.

It is scarcely necessary to remind you of the established legal position regarding consents to operations and anaesthetics. It can be summarized as follows.

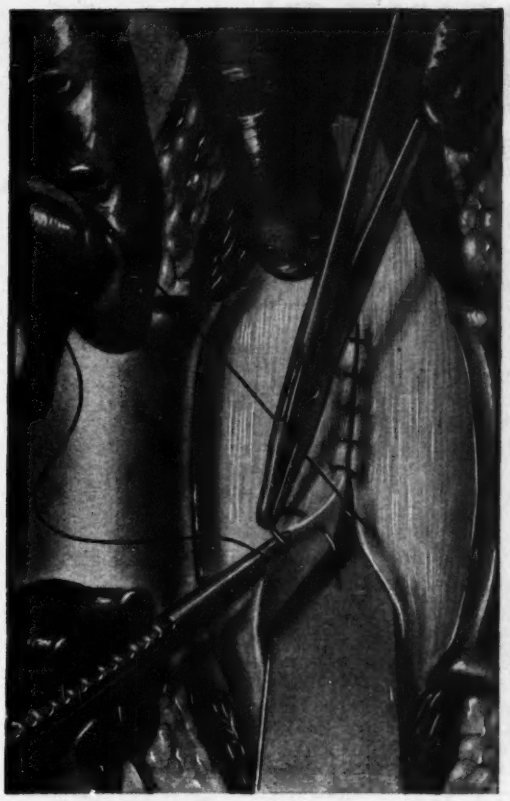
An operation, even a medical examination, carried out without the consent expressed or implied of the person concerned will usually amount to actionable assault. Obvious exceptions are minors-at-law; persons of unsound mind; cases of unconsciousness; severe accident or emergency; and in the case of females where it is deemed prudent to secure the consent of the husband if the proposed operation on the wife may or will result in sterility and so interfere with the husband's marital rights.

Before I had knowledge of the legal action under reference, I had reviewed the forms of consent in use at several hospitals in more than one state. I had been concerned with the adequacy of the forms in use to afford full protection to the hospital and its staff. I found that the forms of consent in use vary considerably, ranging from detailed provision for recording the nature of the operation, the nature of the anaesthetic, the name of the surgeon, and in one case provision for an autopsy, to the other extreme of what may be aptly described as a "blanket" form of consent to any diagnostic or therapeutic procedure including autopsy as deemed necessary and, in this case, the form is signed at the time of admission.

There is something attractive about obtaining the patient's consent in the most general terms when admitted to a hospital so that nothing for which consent is required shall be carried out without consent. I strongly deprecate such procedure, since, in all but most obvious conditions, no one has any idea what operation or other pro-

(Concluded on page 70)

An address, delivered to the Victorian Institute of Hospital Managers and Secretaries, which appeared in "The Hospital Magazine", Melbourne, Australia, June, 1952.



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In suturing with Atraumatic needles there is less tissue trauma, faster and more even healing. The D & G Atraumatic needle is joined to its suture smoothly. Needle and suture are about the same diameter. No big eye and double strand of suture are dragged through the tissue. Sutures on Atraumatic needles are economical, too. Surgery is easier and faster, needles are always sharp, *no time is lost while the nurse threads needles.*

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Consents for Operations

(Concluded from page 68)

cedure may be involved until the patient has been examined or been under observation for some time. Moreover, alternative modes of treatment may be practicable with different degrees of risk. It is, I believe, now generally regarded that a form of consent, signed by a patient on admission in complete ignorance of the nature of the operation proposed or of the pros and cons of any choice of procedure, is quite ineffective.

Whereas it is general for provision to be made in forms of consent for the signature of a witness, in only one instance is the value of this signature assured by the inclusion of an attestation clause, to which reference will be made later.

Instead of a detailed criticism of the various forms in use I will reserve my comment to the forms of consent recommended for use by the Medical Defence Union of Great Britain on the advice of its solicitors prompted by the legal action under reference. The forms include a form of consent for the patient, a form of consent for relatives, and a form of consent for minors.

The Medical Defence Union, with its recommendation to use these particular forms of consent, reminded medical practitioners again of the necessity to obtain proper consent, in writing, from patients and/or their relatives, as the case may be, and that an essential feature of the consent is that an assurance has not been given that the operation will be performed by a particular surgeon who may have seen the patient prior to admission or under whose name the patient is admitted.

There is a surprising omission in the form of consent recommended by the Medical Defence Union and this relates to the provision of a singnature of a witness and appropriate attestation clause. Many years ago I was sadly disillusioned when, at an inquiry into allegations by a parent regarding a lumbar puncture carried out in a case of meningitis, I produced a form of consent signed by the parent and witnessed. The father, in evidence, satisfied the commissioner that, though the form produced had been signed by him, owing to his anxiety and distressed state of mind at the time, he had not appreciated the significance of the form and, further, that the nature and effect of the operation had not been explained to him. The form of consent submitted was ruled as ineffective and the Commissioner's opinion was confirmed by the hospital's solicitors. As a result the solicitors, at the request of the hospital, framed an appropriate attestation clause which has been used at the Royal Alexandra Hospital for Children, Sydney, ever since in connection with forms of consent to operations and anaesthetics, autopsies and removal of patients from the hospital against medical advice. Unless the witness can subsequently, if called upon, testify on oath that the conditions of the attestation clause have been observed, then the mere presence of a signature does not make the form effective or afford protection to the hospital or its staff. A rule of the hospital should, therefore, emphasize the importance of strict compliance with the clause and restrict witnesses to responsible officers.

In conclusion, I am of the opinion that the forms of consent, recommended by the Medical Defence Union of Great Britain incorporating an attestation clause as suggested, afford maximum protection and I commend them for your consideration.

NOTE: While Form I is supplemented by Form II, it is suggested that another complete form similar to the first be used to replace Form I when relatives sign on behalf of a patient. — Edit.

Form I

Consent by Patient

I, ...

of .....

hereby consent to undergo the operation of ..... the effect and nature of which have been explained to me. I also consent to such further or alternative operative measures as may be found to be necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same. I understand that an assurance has not been given that the operation will be performed by a particular surgeon.

Dated this ..... day of ..... 19.....

Signed .....

Read over and explained to the signatory who stated that he/she understood same and affixed his/her signature in my presence.

Witness .....

Form II

Consent by Relatives

I, ...

of .....

the ..... of the above named .....

..... hereby also consent to such operation.

Dated this ..... day of ..... 19 .....

Signed .....

Attestation clause as for form of consent by patient, q.v.

Form III

Consent for Minor

I, ...

of .....

hereby consent to the submission of my child .....

..... to the operation of .....

..... the effect and nature of which have been explained to me. I also consent to such further or alternative operative measures as may be found necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same. I understand that an assurance has not been given that the operation will be performed by a particular surgeon.

Dated this ..... day of ..... 19 .....

Signed .....

Attestation clause as for form of consent by patient, q.v.

"Our Heritage — A Challenge" theme of annual convention.

Catholic Hospital Conference of Saskatchewan

"THIS is our heritage—the Charity of Christ. This is our challenge —the exercise of this charity toward human bodies, but especially toward the souls for whom He died and, in dying, gave us His Charity—our heritage." This is a quotation taken from the President's address at the tenth annual convention of the Catholic Hospital Conference of Saskatchewan, which was held in St. Paul's Cathedral Auditorium, Saskatoon, October 7.

A well-planned program of informative addresses claimed the attention of all delegates. The presiding officer at the opening session was Reverend C. S. Godin, chaplain and bishops' representative for the Conference, who also brought greetings from the Saskatchewan Hierarchy. Other greetings were extended to the delegates by Mayor J. S. Mills of Saskatoon, Dr. B. Sugarman, president of the medical staff, St. Paul's Hospital, Saskatoon, Dr. O. C. Trainor, president of the Canadian Hospital Council, Very Reverend Msgr. A. Towell, president of the Catholic Hospital Association of the United States and Canada, Reverend H. Légaré, O.M.I. executive director of the Catholic Hospital Council of Canada, and J. C. Saunders, business manager, St. Paul's Hospital, Saskatoon.

Sister Pulcheria, president of the Conference presided at the business session. Reports were read by Sister Emilie, secretary-treasurer of the conference, Sister Tougas, chairman of the legislative committee, and Sister Hildegarde of the nursing education committee.

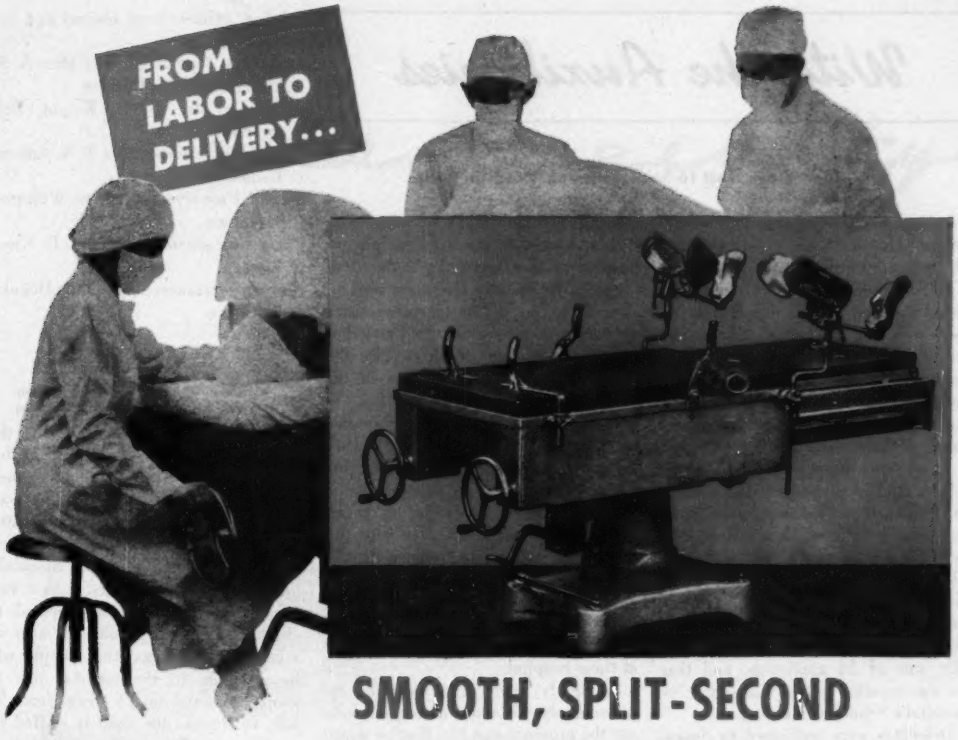
Following the reports, Msgr. Towell spoke on the conference's motto "The Charity of Christ urges us on". He said the purpose of Catholic hospitals was illustrated in the parable of the Good Samaritan. To-day there are thousands of Samaritans among the laity, he said, but the Sisters in hospitals are called upon to practise Charity in a special way. Charity must be the dynamo in their hospitals, the speaker emphasized. He defined Charity as "a giving of onself or one's possessions, with no thought of gain." He also stressed that each member of the staff must exemplify the spirit of Christian Charity in thought, word, and deed. "Let us make our hospitals, citadels of mercy" were his closing words.

Mrs. Leona Skidmore, president of the Saskatchewan Council of Catholic Nurses, traced the history and purpose of this organization; and she reported on the national convention of the Catholic Nurses' Council, as well as the biennial meeting of the Canadian Nurses' Association, both of which were held in Quebec City in May, and

(Concluded on page 96)

New Officers of the Catholic Hospital Conference of Saskatchewan

The new officers of the Catholic Hospital Conference of Saskatchewan were elected at the tenth annual meeting of the conference, which was held in Saskatoon on October 7th.
Pictured above are, front row, left to right: Sister M. Anacleta, Estevan, councillor; Sister M. Pulcheria, Humboldt, past president; Sister M. Laurentia, Moose Jaw, president; Sister Phillipe de Cesaire, North Battleford, vice-president; and Sister Anna Keohane, Tisdale, councillor. Back row, left to right, Sister B. Bezaire, Saskatoon, councillor; Sister M. Elizabeth, Melville, councillor, and Sister M. Edmund, Moose Jaw, councillor.



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With the Auxiliaries

Saskatoon Plays Host to Saskatchewan Hospital Aids

At the opening session of the Saskatchewan Hospital Aids Association's 11th annual meeting the president Mrs. S. S. Alexander of Swift Current, reported that ten new groups had affiliated with the provincial association during the past year. The two-day meeting, held at the Bessborough Hotel, Saskatoon, on Oct. 7th and 8th, was attended by more than 80 delegates, many of them from small towns and rural areas of the province.

Mrs. Alexander praised the women for their accomplishments and said that there were now 88 affiliated aids and that a total of $52,500 had been raised by these groups during 1951. Members also learned that the association's $100 scholarship had been awarded to Beverley E. Smith of Melville, one of 34 applicants, and that she was enrolled in the Saskatoon City Hospital's School of Nursing.

Delegates were welcomed to Saskatoon by Mayor J. S. Mills, who warned them that their chief purpose was not to give financial aid to their hospitals. He continued that they should be careful when making a gift to find out whether the hospital could buy it out of public funds. The Mayor firmly believed that a hospital should buy its own equipment and the chief purpose of an auxiliary should be to give spiritual assistance by visiting patients and by helping to increase the morale of patients and staff.

Secretary-treasurer of the association, Mrs. J. D. Ironside of Swift Current, reported that 800 letters had been sent out in the past year and three district meetings had been held. Mrs. W. B. Frost, provincial representative on the National Council of Hospital Auxiliaries of Canada, outlined the aims and objectives of this organization.

Time was allotted, during the first day of the meeting, to reports from individual auxiliaries. A variety of money-raising ventures were described and included bingo games, canasta and bridge parties, teas, bazaars, tag days, and catering for banquets. One group made presentations to all girls entering their hospital's school of nursing and another made a specialty of hospital visiting, especially to the aged.

At the Wednesday afternoon session, Hon. T. J. Bentley, provincial minister of public health, spoke to the ladies on the possibility of shortening the period of training for nurses in the province. He was hopeful that, in the near future, it might be possible to enrol nursing students at the University of Saskatchewan or at Regina College for four months academic study. Eventually, this period at an educational institution would be increased to include the first ten months of training. If this method were adopted, the students would graduate in two years instead of three and would not be used as a part-time labour force at their hospital.

Currently, there is a need for approximately 350 more nurses throughout the province and Mr. Bentley urged hospital aid members to encourage girls to enter the profession. He stated that he was opposed to students receiving a salary while training as nurses, any more than a university student should be paid while at university, and he was emphatic that the student nurses should not be part of the labour force. At the present time, young women who financially can not afford to enter a nursing school can, by application, receive an outright grant from a special fund set-up to assist students.

High praise was accorded to the auxiliary members by Mr. Bentley, who said, "Your association is an extremely important and integral part of the health services in the province. If we don't have voluntary groups our society is infinitely poorer."

Congratulations were also extended to the delegates by the second speaker of the afternoon, Dr. G. W. Peacock, registrar, College of Physicians and Surgeons, Regina. Dr. Peacock's topic was "The Romance of Hospitals" and he traced their history from the earliest known hospitals in the sixth century B.C. to the present day.

At the conclusion of the two-day meeting, officers were elected and are as follows:

Immediate Past President: Mrs. S. S. Alexander, Swift Current.
President: Mrs. G. E. Wright, Balcarres.
First Vice-president: Mrs. J. N. Adams, Tisdale.
Second Vice-president: Mrs. Williams, Saskatoon.
Third Vice-president: Mrs. J. C. King, Estevan.
Secretary-treasurer: Mrs. MacDonald, Balcarres.

* * * *

Auxiliary Opens "5 Fifty 5" Shop at Sick Children's Hospital, Toronto

At the beginning of October, the ladies' auxiliary to the Hospital for Sick Children, Toronto, Ont., opened an attractive gift shop, which is known as the "5 Fifty 5" Shop as it is located in the hospital at 555 University Ave. Situated to the left of the hospital's lobby, the shop is stocked with a variety of goods which will appeal to children. Gifts for adults are also on sale and it is hoped that people will be attracted to the hospital just to shop. Open six days a week, from 10 a.m. to 6 p.m., the shop is staffed by members of the auxiliary working in two shifts daily. Part of the stock is made by the members.

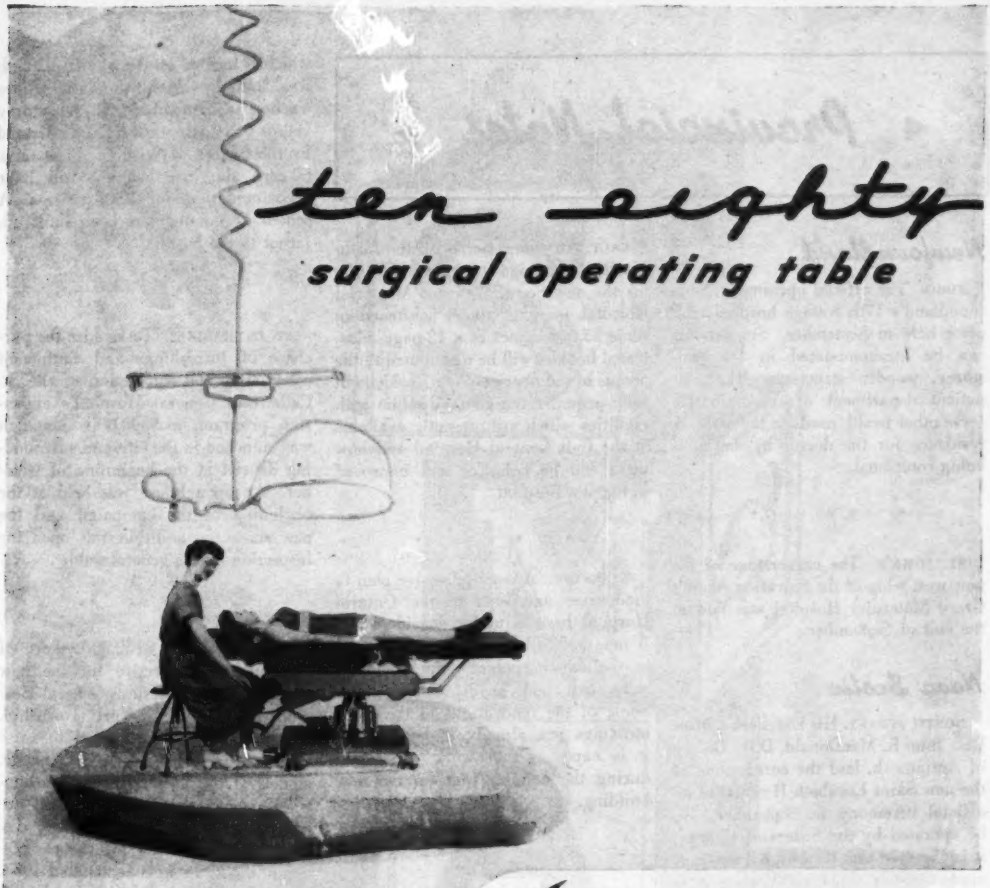
Shortly after the auxiliary was formed, some three years ago, prior to the opening of the new hospital, a rummage sale was held which realized a profit of $400. Material was purchased with the money and was distributed to members to be made into saleable goods. The sale was followed by a mammoth bazaar at which $5,000 was raised. At Christmas, the auxiliary spends nearly $1,000 to buy presents for the children and decorations for the hospital. They have also undertaken to finance a dental clinic for the hospital's convalescent unit at Thistletown. The medical library has also received $2,000 from the auxiliary. In the future, it is hoped that the shop will be the only money-raising venture needed in order to provide funds for the auxiliary's work.

* * * *

Successful Money-raising Ventures Undertaken by Auxiliary

Many successful money-raising ventures were recently undertaken by the

(Continued on page 98)



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Provincial Notes

Newfoundland

FOGO. The official opening of Newfoundland's 17th cottage hospital took place here in September. Six patients can be accommodated in the two-storey, wooden structure. The out-patient department of the unit will serve other health needs in the area. A residence for the doctor in charge is being completed.

* * * *

ST. JOHN'S. The cornerstone of the new west wing of the Salvation Army's Grace Maternity Hospital was laid at the end of September.

Nova Scotia

NORTH SYDNEY. His Excellency, Most Rev. John R. MacDonald, D.D., Bishop of Antigonish, laid the cornerstone of the new Saint Elizabeth Hospital at an official ceremony in September. To be operated by the Sisters of Charity, it is expected that the hospital will cost approximately $3,000,000 when it is constructed and furnished.

Ontario

BELLEVILLE. Hastings County Council will be prepared to contribute $80,000 toward the construction costs of a new 80-bed wing to the Belleville General Hospital. Tentative plans have been prepared for the addition and it is expected to cost approximately $1,000,000 as many of the essential services at the hospital would have to be enlarged and renovated.

* * * *

CHATHAM. The board of trustees of the Chatham Public General Hospital have passed a motion to begin their $2,225,000 building project with the construction of a $1,059,000 addition to the present hospital. Plans will be drawn up for a two-storey addition which may be expanded by three storeys at some future date.

GALT. In connection with the forthcoming campaign to raise $500,000 for the new South Waterloo Memorial Hospital, presently under construction, some 25,000 copies of a 12-page, illustrated booklet will be distributed to the people of the district. The booklet will fully acquaint the general public with facilities which are presently available at the Galt General Hospital and how these will be enlarged and improved in the new hospital.

* * * *

KINGSTON. A comprehensive plan to modernize and enlarge the Ontario Hospital here is under consideration. A new 500-bed hospital will be added to the existing plant, which will be renovated and made fire-resistant. Some of the renovations to the older buildings are already underway and it is expected that work will begin during the coming year on the new building.

* * * *

LONDON. Plans for an addition to the Victoria Hospital's nurses' residence have been announced. The new wing will extend northward from the west end of the present residence to complete the "H"-shaped building. It is expected that the addition will provide space for some 70 beds for nurses.

* * * *

NIAGARA FALLS. The board of governors have approved the recommendation of a special committee to construct an emergency addition to the Greater Niagara General Hospital. The proposed addition, 40 by 35 feet, will be built west of the men's surgical ward and the x-ray department will be moved to this addition. This will permit expansion of the operating theatres in the present building.

* * * *

OTTAWA. The cornerstone of the new St.-Louis-Marie-de-Montfort Hospital, which is located on the Montreal road, was laid by Archbishop Alexandre Vachon in September. The six-storey yellow brick structure will be operated by the Sisters of Wisdom. Built on a 50-acre site, the hospital will have accommodation for 250 patients. A school of nursing has been built adjacent to the hospital.

* * * *

ST. CATHARINES. To finance the purchase of furnishings and equipment essential to the completion of the St. Catharines General Hospital's expansion program, a $300,000 campaign was launched in the city and surrounding district at the beginning of October. An open house was held at the beginning of the campaign and the new six-storey addition was open for inspection by the general public.

* * * *

TORONTO. Still $150,000 short of the campaign objective for the new $1,000,000 Northwestern General Hospital, being built in York Township, efforts are being intensified to raise the needed funds. Nearly 500 plastic models of the hospital, in which contributors can drop small change, are being distributed throughout the district. Estimated date for the completion of the building is September, 1953. The structural steel frame is already up and reinforced steel will be added shortly. The building has been planned for possible expansion, in the future, to a 600-bed hospital.

* * * *

WINDSOR. A new 150-bed wing to the Hotel Dieu Hospital was officially opened at the end of September. The new addition raises the hospital's bed capacity to 465 and provides new operating rooms, a recovery room, and many other facilities.

Manitoba

VIRDEN. The new Virden District Hospital was officially opened in September. To serve the people of Hospital District No. 10, the two-storey building has a bed capacity of 32. On the lower floor of the hospital are located the offices of the Virden Health

(Concluded on page 104)

Notes on Federal Grants

Construction

The Kings County Memorial Hospital, Sussex, N.B., has been awarded a federal grant of approximately $3,700 to help meet the cost of expanding the hospital's bed capacity. An area in the hospital, which was formerly used as a store room, laundry, and drying room, is being converted to provide space for seven additional beds. When the work is completed, the hospital will have a bed capacity of 54.

Hospitals in Ville Marie and St. Hyacinthe, P.Q., have just been awarded federal grants totalling $79,500 to help meet the costs of extending their facilities. The Holy Family Hospital, Ville Marie, is being enlarged to provide space for 50 additional beds, a 33-bed nurses' residence, a new heating plant, laundry, and kitchen. This hospital, operated by the Grey Nuns of the Cross, serves about 20,000 people in the county of Temiskaming and part of Rouyn-Noranda. When the additions are completed, it will have a bed capacity of 85. The federal grant toward this work will be $66,500.

At St. Hyacinthe, the St. Charles Hospital is increasing its diagnostic facilities for both in-patients and out-patients by converting a former operating room and medical records room into laboratories for pathology, chemistry, bacteriology, and related services. The federal grant towards the costs of the alterations will be more than $13,000.

At the Vancouver General Hospital, Vancouver, B.C., alterations are being made which are designed ultimately to bring the hospital's paediatric department under one roof, to provide better out-patient facilities, laboratories and operating rooms, and to increase the bed capacity so that it can more rapidly take care of the long waiting lists of children. The federal grant toward the initial phase of this program will be $62,000.

St. Joseph's Hospital, Comox, B.C., is converting space formerly used as a dining room into accommodation for four additional patients. The federal grant toward this work will be one-third of its cost or about $1,500.

Expansion of the Ponoka Municipal Hospital, Ponoka, Alta., will provide space for 22 more beds, an 11-bassinet nursery, and an enlarged x-ray suite. This hospital serves an area of 576 square miles with a populaton of about 8,400. The federal grant toward this construction, scheduled for completion before the end of this year, will be more than $25,600.

At the Rocky Mountain House Municipal Hospital, Rocky Mountain House, Alta., new consrtuction will provide space for surgical, obstetrical, and x-ray services, a nine-bassinet nursery, and space for 13 more beds. When the extensions are completed, the hospital will have a bed capacity of 35. The federal grant will be $17,000.

A new wing is being added to the Viking Municipal Hospital, Viking, Alta., to provide space for 22 additional beds; a nine-bassinet nursery and surgical, obstetrical, and x-ray facilities. This wing is scheduled for completion by the end of this year, with the federal contribution being $25,000.

Mental Health

The Ottawa General Hospital has just been awarded a federal health grant to assist in setting up a mental health service. Plans involve establishing out-patient mental health clinics for both adults and children. The clinic for adults will function three half-days a week and will be staffed by a full-time psychologist and a psychiatric social worker. The clinic for children will also be open three half-days a week. It will be staffed by a psychiatrist, working part-time, and a psychologist and a psychiatric social worker, both working part-time. Plans also call for an in-patient service for a maximum of 30 patients.

Part of the treatment program for in-patients and for a considerable number of out-patients will include occupational therapy. The federal grant will be used to meet the salaries of two occupational therapists and to help provide occupational therapy equipment.

The clinical services to be developed will be directed by Dr. Karl Stern, noted psychiatrist, who has joined the staff of the University of Ottawa's medical school as professor of psychiatry and is psychiatrist-in-chief at the Ottawa General Hospital.

Professional Training

Several public health bursaries have been awarded to residents of the Prairie Provinces. In Alberta, a technician on the staff of the Alberta provincial laboratory has received a bursary which will enable him to take a two-year course in mycology at Harvard University, Cambridge, Mass. On his return, it is hoped to expand the medical mycology services available to doctors in Alberta. Another Alberta resident will receive a year's training at Chalk River, Ont., in the use of radioactive tracers in medicine. On his return he will joint the staff of the University of Alberta Hospital, Edmonton.

In Saskatchewan, seven bursaries have been awarded. A staff member of the Saskatchewan provincial psychiatric services branch will study at Harvard University, where she will specialize in techniques of research in sociology, clinical psychology, and social relations. On her return she will continue her work in testing and evaluating new programs, both teaching and treatment, being developed by the province's mental health specialists. A man from Prince Albert will spend a year at the University of Michigan's School of Public Health, where he will take post-graduate training in health education. A bursary has also been granted to a member of the provincial laboratory staff in Regina to take a short course in syphilis serology at the federal laboratory of hygiene, Ottawa. The remaining four bursaries go to the superintendent of the Canora Union Hospital, the secretary-manager of the Wadena Union Hospital, the accountant with the Swift Current Union Hospital, and the accountant with the Yorkton General Hospital, to help cover the cost of taking the Canadian Hospital Council's extension course in hospital administration.

Two awards have been made to residents of Manitoba. A man from Winnipeg will spend a year at the McGill School of Social Work, Montreal, where he will complete a course in

(Concluded on page 110)

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(1) Hanson, I. R. and Hingson, R. A., *Current Researches in Anesthesia and Analgesia*, 29:136 (May-June) 1950.

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As soon as the regional board saw the plan and statement of need they included it in their capital program with an immediate starting date. The tender accepted for the erection of the buildings was from a firm of repute and came well within the estimated cost of the work. Steel, timber and other authorisations, were speedily forthcoming and the whole project met the progress deadline to the very day.

Ample provision had been made in advance by the management committee for maintaining the hospital and its services so that, the day after the paint was dry, cars, buses, and ambulances started to run up the carefully designed approach ways and park in the most convenient places as indicated in white lines and lettering.

The hospital staff had been selected from people "eminent in their particular sphere". The professional element represented just that delicately correct balance between the various specialities and was adequately supported by auxiliaries. The matron was considered to be one of the most efficient in the country and the qualifications and training of the nurses were beyond question. Equal care had been exercised in selecting the administrative, technical and ancillary grades of staff. A foolproof accounting system had been established and the hospital records and appointments systems soon began to draw admiring students on day refresher courses.

The Quality of Administration

or

Hope for the Heretic

C. A. S. Brooks, D.P.A., A.H.A.

The management committee chairman surveyed the completed hospital in occupation, exchanged a look of incredible satisfaction with the group secretary and went home in the sure and certain hope of future administrative bliss.

Six months passed by and it was noticed that the smiles passing between the chairman and the group secretary at the mention of hospital X were decidedly thinner. At the end of twelve months the secretary tended to avoid the chairman's eyes when the reports from the house committee were received. The glowing phrases appearing in the management committee's annual report on the completion of hospital X found no place in the report for the subsequent year.

The management committee grew restless and the chairman, deciding that "something must be done", asked the secretary for a report. The chairman scanned the secretary's report eagerly but found in it little to explain his uneasiness about hospital X.

The volume of work undertaken was equal to that achieved by comparable hospitals; there was a full complement of staff; maintenance costs were below average; the building itself in its unique setting still looked like a dream hospital, and visitors were still impressed by the brightness and cleanliness of the buildings and equipment and the general air of efficiency.

Another year crept by uneasily, with members of the committee appearing very reluctant to discuss their new hospital or to witness to any miracle which might have been observed within its walls. The chairman, the official visitors, the group secretary, and the auditor all visited the hospital regularly and came away wearing an uneasy and puzzled expression.

At the end of the third year, the group secretary was visiting hospital Y, a dowdy grey rambling old place originally constructed as a poor law institution. He could not find a place to park his car in the little driveway where the gardener was fighting a losing but cheerful battle with weeds and torn rambler roses. The secretary saw, waiting outside the matron's office, two staff nurses from hospital X. They were apparently seeking a transfer to hospital Y because "we have friends here". Now the secretary knew that both nurses were recently recruited at hospital X and asked them whether they would not miss the unparalleled facilities offered in their present posts. They replied vaguely that "good buildings and equipment were not everything" and changed the subject. He found matron, with a sister and the catering officer, in an enthusiastic discussion about a birthday party being arranged for a long-stay patient. The party was to be held in a little retreat in a sunny spot of the garden which the staff had constructed in their spare time. A porter hammered enthusiastically on the door

(Continued on page 92)

This article appeared in "The Hospital", Aug., 1952, and is reprinted through the courtesy of the editor and of the author who is deputy secretary of the East Devon Hospital Group Hospital Management Committee.

Payment by Third Parties

(Continued from page 22)

ever, is a debatable point.

It will be noted that the Act refers to the "cost of maintenance", but no provision is made therein as to the method by which this cost shall be ascertained. In practice, it falls to the Minister of Health to determine the daily cost of treating an indigent patient. In the absence of a uniform system of accounting by the hospitals, the Minister has no alternative but to establish arbitrarily an estimated cost of treating ward patients; and in most cases this results in the hospitals receiving less than that to which they are entitled in accordance with the provisions and intent of the Act. At the present time many hospitals are bearing one-half of the cost instead of one-third as laid down in the Act. In our own hospital the average cost of a public patient is approximately $11.25 per day, towards which we now receive $5.50 per day under the Charities Act. Hospitals cannot continue indefinitely to carry this burden from their own resources, which means, of course, periodic appeals to the public for funds to offset deficits.

Generally speaking, voluntary hospitals can do a commendable job at a lower cost; but the fact that they are called upon to bear more than their share of the cost of treating indigent patients means that they must continue to increase the charges for private and semi-private patients in order to obtain funds to offset the cost of treating indigent patients. The thought arises whether it is justifiable for the Government to collect taxes from the public to pay for the hospitalization of indigent patients, and also for the hospital indirectly to assess, for the same purpose, those members of the public who are able to pay for private or semi-private accommodation.

A further responsibility which the voluntary hospitals are called upon to bear is the heavy cost incurred in treating indigent out-patients. The provincial and municipal governments have not as yet recognized their obligation to give financial assistance towards the cost of treating such patients. In some hospitals the deficit in this department is almost as heavy as that incurred in treating indigent in-patients; but here again is a problem which depends to a large extent upon uniformity in the determination of true costs.

Workmen's Compensation Commission

The Compensation Commission recently agreed to pay hospitals their prevailing rates for public ward accommodation and, if it is necessary to hospitalize the injured person in a semi-private bed, to pay also the hospital's prevailing rate for that type of accommodation. In addition, the Commission pays for those extra services necessary to the treatment of the injury, but in accordance with their own tariff for such services. To pay the prevailing rates for accommodation is a step in the right direction; but this is another instance where the hospitals would be fully justified in asking for payment based on "full cost" if the hospitals were able to produce figures to show what the full cost actually is. The Commission obtains its funds by assessments on industrial payrolls and industry is fully prepared to meet its obligations in regard to injured workmen.

Voluntary Pre-Payment Plan

As group hospitalization plans usually provide for semi-private accommodation, the question of cost is not a paramount problem. The charges for semi-private accommodation and for the extra services given to semi-private patients are usually sufficient to cover the full cost of treatment. The principal difficulty which confronts the hospitals in this regard is the relationship between the patient, the hospital, and the Plan. In general, pre-payment plans are of two kinds:

(a) those underwritten by commercial insurance companies; and

(b) the "Blue Cross" Plan.

From the standpoint of the hospitals, payments made under the two plans are based on different principles.

Commercial Insurance Plans

The "privity of contract" in group hospitalization plans underwritten by commercial insurance companies is between the patient and the insurance company. The company undertakes to to pay to the insured a certain sum of money in the event that the insured is hospitalized. There is no agreement between the company and the hospital. Although the hospital, as a convenience to the patient, may agree to await payment of the account until the company makes a settlement or to make certain allowances equal to those to which the insured is entitled under the terms of his policy, it should be clearly understood that, in the final analysis, the patient is responsible for the full payment of his account. In the event that a hospital does agree to make allowances on the bill, it should obtain from the insured an assignment of the hospital benefits provided in his policy, up to the amount of such allowances. The hospital should not assume that because the patient is insured under a group hospitalization plan underwritten by a commercial insurance company that the patient is entitled to a corresponding reduction in his account. The hospital cannot collect directly from the insurance company the sums due to the insured without an assignment, for unless the insured assigns to the hospital, in writing, his benefits under the policy, the company has no alternative but to pay them directly to the insured person. Even though an assignment may be given, the insured may revoke this at a later date but before payment is made by the company if he wishes to do so. To avoid misunderstandings it is prudent to impress upon a patient covered by a commercial group hospitalization plan that he is primarily responsible for the

Enroll Early for C.H.C. Extension Course, 1953

Within the past year, two classes have been enrolled in the Canadian Hospital Council's extension course in hospital organization and management. In 1951, it was necessary to request a large number of applicants to defer their enrolment for one year as the first class had been filled. The same was true in 1952. Already there are a number of applications on file for the 1953 class.

Therefore, it is suggested that persons presently engaged in hospital work who wish to enrol in the extension course, commencing in the fall of 1953, should file their applications now rather than wait until the closing date, March 31, 1953.

Application forms and information concerning the extension course may be obtained from the Secretary, Committee on Education, Canadian Hospital Council, 230 Bloor St. W., Toronto 5, Ont.

Other Canadians Honoured at A.C.H.A. Convocation

(see page 44, October, 1952)

Sister M. Berthe Dorais
St. Boniface, Man.

L. Reginald Adshead
Edmonton, Alta.

full payment of his account.

"Blue Cross"

In the case of the Blue Cross plan however, the "privity of contract" is between the hospital and the hospital service association. The hospital enters into an agreement with the association whereby it undertakes to provide hospital service to the association's subscribers. Also, the hospital agrees to make certain reductions in the subscriber's account. The subscriber is called upon to pay only the difference between the hospital's regular charges for the type of accommodation occupied and the total of the allowances granted him as a Blue Cross patient.

Because of the marked differences between the two forms of contract and the fact that hospitals, through representation on the boards of hospital service plans, are able to guard their own interests, it is to the advantage of the hospitals to encourage the growth of "Blue Cross". It should be remembered that "Blue Cross" group hospitalization plans were originally sponsored by the hospitals. It should also be borne in mind that the acceptance by the public of continuously increasing rates for hospitalization is mitigated to a large extent by membership in a pre-payment plan. In some hospitals in the United States, Blue Cross now provide almost 50 per cent of current income from services to patients. In 1951 the Quebec Blue Cross plan, with 633,000 subscribers, paid nearly $5,250,000 for hospital services.

Bases of Negotiation

Having discussed the bases upon which payments by third parties are made to hospitals in this province, it might be appropriate to discuss, also, the general principles which should be borne in mind by the hospitals in negotiating with third parties.

There appears to be no agreement among the hospitals as to the basis upon which they should sell their services. Hospital administrators differ in the definition of "full cost". Should undergraduate education be part of cost? Is it permissible, in the case of voluntary hospitals, to include an allowance for depreciation, interest and use of capital? If depreciation is included, will this sum be set aside for the purpose of replacing buildings, or will it be absorbed in the general operating income of the hospital?

The Blue Cross Commission of the American Hospital Association laid down as a principle to be accepted by the hospitals that "hospitals should not expect payment from Blue Cross for service provided to subscribers in excess of the cost of such services to include an allowance for depreciation of buildings and equipment and allowances for other contingencies". On the other hand, Blue Cross Plans are to accept the principle that "Blue Cross should not expect the hospital to accept a rate of payment for services to subscribers which would force the hospital to use trust and other funds to make up the difference between payments received and the cost of service to Blue Cross patients". These principles can be applied equally well to all third parties who buy hospital services. It is also fundamental that if the hospitals expect to receive payment of "full cost" they must, in return, be prepared to provide adequate facilities; to use uniform accounting and costing methods; and to co-operate with non-profit and governmental agencies in studying factors which affect cost.

One aspect of the hospital situation which is often overlooked by the business-man who finds it is difficult to understand why hospitals have deficits is that hospitals are dealing with human beings and not in commodities. Only under special circumstances and for a very limited time would a manufacturer sell his product at less than cost. Hospitals, however, by the very nature of their aims and purposes, are often compelled to relegate financial considerations to a secondary place when a sick person, obviously in need of immediate hospital care and attention, applies for treatment.

In addition, they are in the position of being unable either to withhold or withdraw their service if they fail to obtain payment of full cost. If it ever comes about that the voluntary hospitals refuse care and treatment to the needy sick until they are satisfied that the cost of such care will be paid in full either by the patient himself or by a third party, it will be a sad day for the welfare of the community at large.

Public policy and general welfare require that medical and hospital care should be provided to everyone, regardless of whether he is able to pay himself or whether someone else is prepared to pay for him. To function properly, however, hospitals require adequate income. It is therefore only right and just that they should take all necessary steps to ensure that they obtain all the "earnings from services to patients" to which they may be entitled.

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Cobalt 60 Unit

(Concluded from page 35)

(c) For beam direction in sites where a plaster cast is unsuitable, a Manchester pin and arc attachment is fitted to the master-cone (Figure VI). A small spirit-level is attached to the pin so that it can easily be determined when the pin is vertical.

Rotational Therapy

Set into the centre of the floor, at floor level, is a circular steel platform, 8 feet in diameter, covered with linoleum. This platform may be made to rotate at varying speeds by pushing a button on the control panel. By means of a light in the ceiling focussed at the centre of the platform, the patient (lying on a treatment couch or sitting up) can be positioned so that a tumour, situated deep in the body, is directly over the axis of rotation. The cobalt unit, the centre beam of which traverses this axis, can be brought into position so that during rotation the beam continuously irradiates the deep tumour but strikes a changing skin surface. In this way, a large dose can be administered to a deep tumour, without delivering a high dose to any skin.

Protection

The unit points always outwards or downwards. Thus the direct beam always strikes either the floor or an outside wall. Beneath the floor (one foot of concrete) there is a storeroom, which cannot be entered when the machine is running. Lights over the door of this room, and also in the room itself, provide warning when the machine is operating. Considerable protection from the scattered rays must be provided in the walls of the room (Figure VII). Each wall is concrete, one foot thick. The viewing window consists of eight inches of plate glass. There are no floors above this room. The radiation level is below tolerance at all points outside the room so that satisfactory protection is provided the technicians.

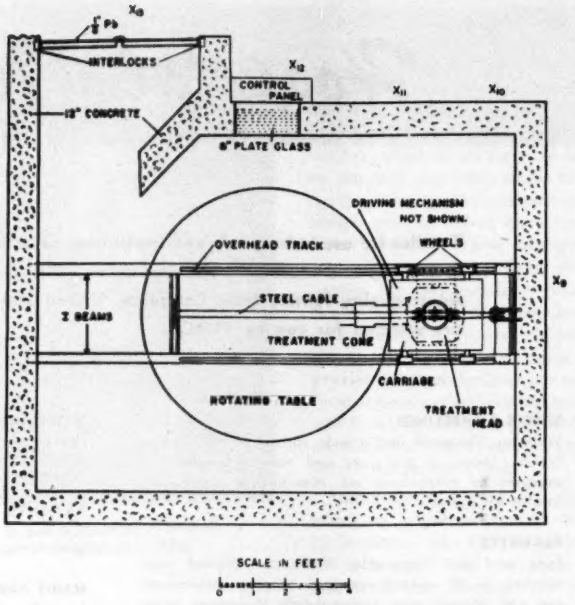


Figure VII: Layout of Treatment Rooms.

◀Book Reviews▶

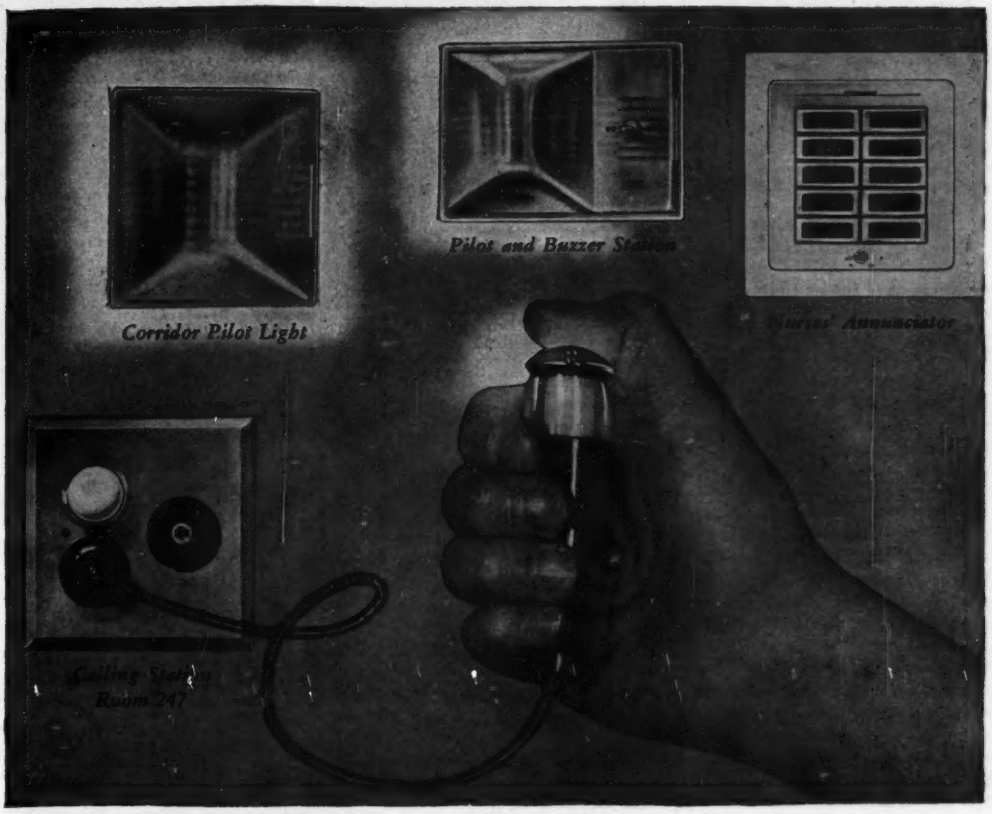
THE CARE OF THE AGEING AND CHRONIC SICK. By A. P. Thomson, M.D., Ch.B., F.R.C.P., dean of the faculty of medicine and professor of therapeutics, University of Birmingham, and chairman of the planning committee of the Birmingham Regional Hospital Board; C. R. Lowe, M.D., Ch.B., M.R.C.S., D.P.H., lecturer in public health, department of social medicine, University of Birmingham; and Thomas McKeown, Ph.D., D. Phil., M.D., professor of social medicine, University of Birmingham and member of the Birmingham Regional Hospital Board. Pp. 133. Illustrated. Price $1.45. Published by E. & S. Livingstone Ltd., Edinburgh and London, 1951. Canadian agents, The Macmillan Company of Canada Ltd., Toronto.

This 133-page booklet comprises a series of excellent lectures and papers which were originally published in the *British Medical Journal* and the *British Journal of Social Medicine*. The writings are based on an investigation, carried out for the Birmingham Regional Hospital Board, into the problems of the aged and chronic sick in the area—the majority of whom were accommodated in infirmaries which had evolved from the workhouses established under the Poor Law Act of 1834. Thus most of the research is based on a study of over 1,000 patients of the Western Road Infirmary, Birmingham, while a similar study was made later in Stoke-on-Trent to confirm the accuracy of the original findings.

In addition to very useful statistics on admissions (age and conditions), length of stay, discharges, medical and nursing requirements, medical findings, and so on, these accounts are interspersed with full discussions on administrative, and social aspects of the care of the aged and chronic sick.

Among the significant findings of this investigation are the following facts. It was found that only 20 per cent of the patients examined require the services of an active treatment unit; that the great proportion, 60 per cent, need only minimal medical nursing attention if good domestic care is available; that the provision of hospital beds to care for this latter group is neither feasible nor desirable; that a broad health-welfare attack on the problem is needed; and that prevention and avoidance of institutional dependency is a "must".

Illustrated by tables and graphs, written in concise and interesting style, the report is timely and well worth the attention of all interested in this acute problem.—*L.O.B.*



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A signal lights on the patient's own calling station, assuring him that the system is functioning. Simultaneously the corridor pilot light over the room door is illuminated, as well as the pilot and buzzer stations located in diet kitchens and utility rooms. The number of the patient's room is lighted on the Annunciator at the Nurses' Duty Station, indicating to the nurses which room has registered a call.

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Alberta Hospitals Convene

(Continued from page 43)

use of germicidal lamps. These subjects were most capably presented by several prominent representatives of hospital supply houses and the discussion was chaired by H. A. Howard, chairman of the board of the Holy Cross Hospital, Calgary.

Municipal Hospital System

Provincial minister of health, Dr. W. W. Cross, reviewed the origin and development of the municipal hospital system in Alberta. The minister laid emphasis on the fact that the system had its beginnings in 1919 and was, therefore, the oldest scheme of its kind in Canada. Dr. Cross traced the developing complexity of the many hospitalization plans in the province and promised provincial help in administration and in extension of coverage. He announced that a provincial commission was in the process of formation and that H. P. Wright of the Calgary General Hospital's board, had been appointed to the commission as the representative of the Associated Hospitals of Alberta. Dr. Cross stated that his government is willing to subsidize organizations which will sell hospital insurance to cover the cost of "extras" as long as policies would not cover the one dollar a day patients now have to pay for standard ward care. The "extras", over and above the basic rate which covers bed, board, and nursing, would be paid for by the proposed policies with a 50¢ per day charge acting as a further deterrent to over-utilization of hospitals. This suggestion would also comply with the government's policy of having the patient pay for part of all he receives. When details have been completed, the minister estimates that Alberta residents would have the finest possible care for a direct cost of $1.50 per day.

Accounting and Statistics

Bernard R. Blishen, chief, institutions section, Health and Welfare Division, Dominion Bureau of Statistics, addressed the meeting following Dr. Cross. He outlined the development of hospital statistics in Canada, stating that Canadian statistics and methods were highly regarded by many countries and were being used, in many instances, as the pattern for developments elsewhere.

Accomplishments made at the Dominion-Provincial Conferences on hospital statistics were reviewed and the revised reporting schedules described. Copies of the Canadian Hospital Accounting Manual were passed out to delegates and were used for frequent reference when Murray Ross, associate secretary of the Canadian Hospital Council, described the manual's development, content, and purpose. The announcement of the formation of a provincial fact-finding committee on hospital costs, by the minister of health, was cited as proof, if any was needed, that the standardization and improvement of hospital accounting and statistical records was highly important to the hospitals themselves.

John McGilp, supervisor of hospital administration, Alberta department of public health, reviewed the position of accounting and statistics in the province. Mr. McGilp held out the possibility of introducing report accounting whereby the smaller hospitals might submit basic data monthly to the department of health, with the department accumulating the data and preparing the necessary summaries and reports.

The Association of Hospital Matrons met as a group, on Friday morning, to discuss problems of common interest. After this session, a number of resolutions were placed before the general assembly by Lois Kremer, Reg.N., chairman, and also by Mrs. Clara Van Dusen of the Alberta Association of Registered Nurses.

Divided Sessions

Hospitals in groups "A" and "B", held a round table conference on questions affecting the larger hospitals, under the chairmanship of Dr. D. R. Easton, Edmonton. Group "C", "D", and "E" hospitals met together and were chaired by S. H. Edwards of Bassano. The program for the latter group was introduced in an address by the Hon. Dr. W. W. Cross. E. E. Maxwell, supervisor of Municipal Hospitals, introduced 15 new secretaries of municipal hospital districts. Mrs. Grace Storey, chairman, board of trustees, Municipal Hospital, Empress, Alta., spoke on the role of trustees.

After a short recess, Lois Kremer, formerly matron of the Hanna Municipal Hospital, Hanna, Alta., and now associated with the provincial civil defence organization, presented her case for matron-superintendents. In rebuttal, problems of the hospital secretary were ably described by H. J. Peddie, secretary-treasurer, Brooks Municipal Hospital District. A general discussion followed.

At the annual convention dinner, held Friday evening, Dr. A. F. Anderson of Edmonton, received the George Findlay Stephens Memorial Award for 1952, presented on behalf of the Canadian Hospital Council by its vice-president, Dr. A. C. McGugan, Edmonton. The citation accompanying the award was read by Dr. A. L. Swanson, executive secretary, Canadian Hospital Council (see page 42).

A stirring address by the guest speaker, Rev. Dr. G. B. Switzer of Calgary, was entitled "What Prospect Peace". The horror and tragedy of war was described in gripping fashion by Dr. Switzer, who said that war must go as an instrument of decision, as

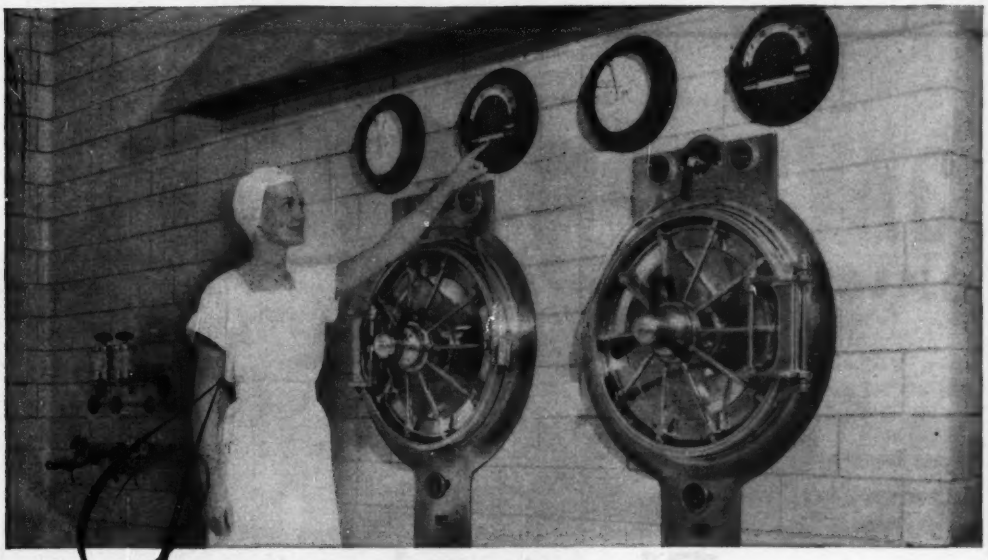
(Concluded on page 118)

New Booklet Published by WHO

The World Health Organization Centre for Classification of Diseases has prepared a booklet, entitled *Comparability of statistics of causes of death according to the fifth and sixth revisions of the International List*, designed to indicate the difficulties encountered in maintaining continuity of statistics of causes of death and how those difficulties may be overcome and comparability achieved.

This publication is intended to assist those concerned with the preparation and study of trends of death-rates from separate causes. Methods of preserving continuity of statistics of mortality rates are discussed and examples of possible situations given. The final 24 pages are devoted to three tables: the first giving the International List categories, sixth revision, expressed in terms of categories of the fifth revision; and the second and third, the deaths in Canada in 1949 coded according to the fifth and sixth revisions and grouped according to the Intermediate and Abbreviated Lists respectively.

The 59-page booklet may be obtained through the World Health Organization, Palais des Nations, Geneva, Switzerland, at a cost of 50¢. It is also available in a French edition. ●



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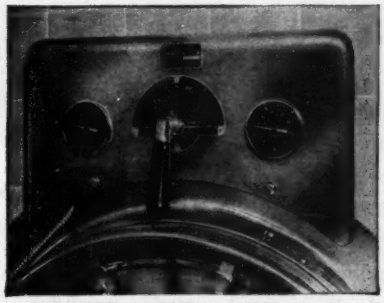

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This engineering achievement will virtually eliminate all possibility of tampering or human error, as the control clock key can remain in constant possession of one responsible individual.

This functioning is in conjunction with the exclusive Thermatic automatic recycling mechanism, and the guaranteed sterility of each and every load thereby becomes a simple matter of routine, attention-free mechanics.

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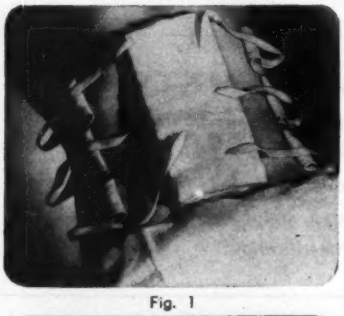

Fig. 1

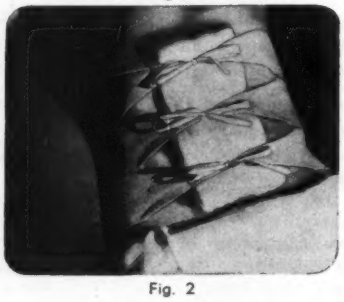

Fig. 2

When frequent dressings are necessary, the following method of applying Elastoplast may be used as a substitute for an abdominal many-tailed bandage.

Six pieces, each about 12 inches in length, are prepared from a 3-inch wide Elastoplast bandage. Tapes are attached and the completed pieces applied to the body from each side (Fig. 1). The tapes are tied over the dressing covering the wound (Fig. 2). The bandage may be applied by one person without disturbing the patient. It is easily made, provides adequate support and will remain firmly in position.

The above method is comfortable in use as the patient does not have to wear perineal stirrups to keep the bandage in place or to lie on a bandage which may become 'rucked-up'—disadvantage associated with the flannelette type of many-tailed bandage.

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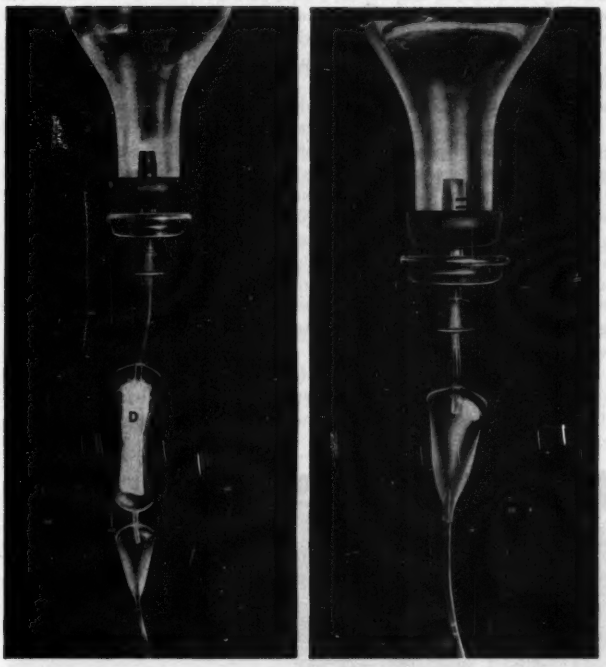

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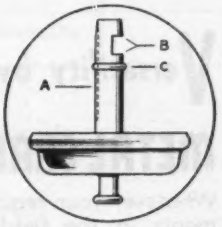

The stem of the Tel-O-Vac Seal is fabricated to include a 2-way air vent (A) and inside strainer (B) as illustrated. Note supporting ring (C) which establishes the proper point at which the Seal should be set prior to attachment of Fenwal Universal Sets.

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*Sack, Theodore et al, The Preservation of Whole ACD Blood Collected, Stored, and Transfused in Plastic Equipment, Surg. Gyn. Obst. : 95, 113-119, 1952.
Walter, Carl, W., A New Technic for Collecting, Storage and Administration of Unadulterated Whole Blood. Surgical Forum.
Walter, Carl W., and Murphy, Wm. P. Jr., A Closed Gravity Technic for the preservation of Whole Blood in ACD Solution utilizing Plastic Equipment. Surg. Gyn. Obst.: 94, 687, 1952.

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Hope For the Heretic

(Continued from page 80)

to announce that he had found a way of negotiating a wheelchair over the pot-holes in the garden path leading to the "retreat". The secretary was persuaded to lend a special tea-set for the party and came away from the matron's room in a happy frame of mind, passing a mental resolution to the effect that he did after all feel capable of looking through his S.H. 3 and S. H. 5 returns that evening. As he passed through the office on the way out he saw a ward sister and the out-patient sister discussing with the medical records officer a revised form of return which would satisfy the insatiable demands of the Ministry and the regional board for statistics. Although both sisters wore a wry expression he could see that the discussion was a good humoured one and that it was progressing to the mutual satisfaction of all concerned. As the secretary was getting into his car he saw the engineer and a stoker, discussing the latest report on a boiler which had been threatening to resign for some years. It was obvious from the discussion that the stoker had something of value to say from his experience of tending the boiler and the engineer was prepared to hear it. This reminded the secretary that he had promised to attend that afternoon a meeting of the joint consultative committee at hospital X and he accelerated fiercely up the narrow winding road leading up to the town.

There were only five items on the agenda of the joint consultative committee and four of these were dispatched formally and speedily. The management representatives sat on one side of the table and the "employee" side was ranged, in order of seniority, on the other. The secretary's efforts to produce spontaneous discussion were received coldly. On the last item of the agenda the chairman, feeling that nothing much in the way of joint consultation had taken place, asked if anyone would like to ask a question. After ten seconds of uneasy silence the theatre sister asked why modifications to fittings and equipment in the theatre were always done in her absence or without her knowledge. The hospital administrative officer replied that it was only logical that work in the theatre should be done when it was not in use, when presumably the theatre sister would be off duty and, that in any case, the work undertaken was of a specialised kind with which the engineer was competent to deal without too much help.

Vague thoughts which had been running through the secretary's mind began to crystallise. That evening, instead of looking through the annual hospital return, he read some books he had had on his shelf for some time. They were Joan Woodward's "Employment Relations in a Group of Hospitals", Mary Parker Follet's, "Dynamic Administration", and Dr. Northcott's, "Personnel Management". Three statements struck him with particular force:

"The final measure of the strength of an organisation is the collective strength of the individuals who are concerned in its operation. This applies

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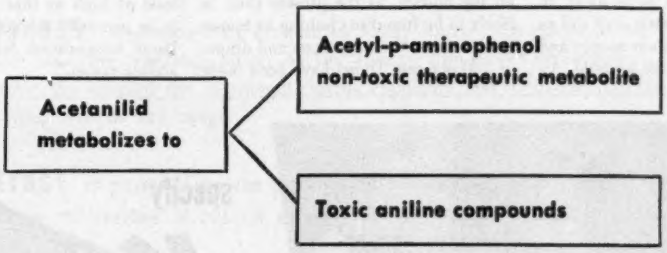

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not only to the high executives, but to all employees, for each one, be his task relatively great or little is charged with his own measure of responsibility for the final result".

"Any hospital, to function efficiently, requires a good organisation, and the fullest degree of collaboration among its staff."

"Functional unity is achieved when supervisor and worker together accept the order of the situation."

He was gradually beginning to see that hospital X consisted of a series of separate, professionally jealous departments which, although staffed by a highly qualified personnel, revealed a rigid caste system and gave too little evidence of a desire to co-operate for the benefit of the service as a whole. The matron regarded the senior administrative officer as an unmitigated nuisance who thwarted her plans by objections involving budgetary control and establishment quotas. The nurses were convinced that they were collecting information at great inconvenience for clerks to store away in files, and that the domestic staff did as little as possible to get their money and were not interested in the hospital. Although there was always a full complement of staff, the rate of turnover was unusually high. The secretary thought again of hospital Y. Here, if ever there was one, existed an integrative unity. Yet he was convinced that neither the matron nor senior administrative officer of hospital Y had heard about Mary Parker Follet. The next day, however, he visited hospital Y and saw matron and the administrative officer discussing staff problems over their elevenses. On the wall above matron's chair was framed a faded piece of paper. It read:

"It is something to be able to paint a particular picture, or to carve a statue, and so to make a few objects beautiful; but it is far more glorious to carve and paint the very atmosphere and medium through which we look . . . to affect the quality of the day—that is the highest of arts".

Watch Out for Dynel!

Dynel, the most heat-sensitive fibre on the market, at the present time, is likely to be found in clothing or household textiles. Some blankets and drapes of 100 per cent Dynel have been made in the United States and a number of lines of dress fabrics contain Dynel blended with other fibres. Dynel shrinks and hardens at temperatures above 240 degrees F. and thus even temperatures which are safe for pressing acetate rayon can damage Dynel.

According to the *Technical Bulletin* of the Canadian Research Institute of Launderers and Cleaners, September, 1952, "Dynel has many good properties which make it valuable for certain industrial uses but, because of its heat sensitivity, it is our opinion that its use for clothing and household fabrics introduces a serious serviceability hazard for the consumer public as well as for fabric-servicing industries such as commercial laundries and dry cleaning plants. With the wealth of natural and synthetic fibres now available, it would seem unwise to make use of such a heat-sensitive fibre for clothing and since it is impossible to predict that any item of clothing or household textile will not be subjected during its lifetime to temperatures at least as high as that which has come to be generally recognized as the maximum temperature which is safe for acetate rayon."

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2

Clarity

The clarity of an X-ray image is decided by its sharpness, contrast, and resolution of fine structures in the radiograph.

Sharpness is governed by breadth of X-ray source, the extent of movement during exposure, and the resolving power of the film or film-screen combination. The narrower the source, the smaller the movement during exposure, and the higher the resolving power the sharper will be the image.

Contrast is governed by the ability of the emulsion to reproduce, or if necessary exaggerate, differences in subject opacity. It can be destroyed by fog and scattered radiation.

Resolution is basically a property of the emulsion. In theory more lines per unit length can be resolved without an intensifying screen than with. In practice the greater relative sensitivity to scattered rays, when no screens are used, increases the degrading effect, and the longer exposure may bring in loss of sharpness through movement. The result is that intensifying screens often actually increase definition in the finished radiograph.

Sask. Catholic Conference

(Concluded from page 72)

which she attended as a delegate.

During the afternoon session, Reverend C. Kramer C. Ss. R., chaplain of St. Paul's Hospital, presided. Many interesting addresses were presented. Sister M. Hedwig, C.S.J., of Radville, spoke on "The Catholic Hospital, Our Heritage". She quoted from Pope Pius XII's encyclical on "The Mystical Body of Christ" to show that love must be shown to the rich and poor alike. Christ's words, "Go, and do thou in like manner", the speaker said, were addressed to all Apostles of Mercy. Reverend Henri Légaré, O.M.I., chose as the topic of his informative address "A Double Challenge to Catholic Hospitals". In his talk, Father Légaré declared that "only the hospital imbued with sound Christian principles can see the patient in the proper light—as Christ Himself, as a being endowed with both a body and soul and called upon through suffering to make reparation, to do penance, to acquire merit, to prepare for a future life where hospitals will no longer be needed." When the personnel of a Catholic hospital has meditated profoundly on the truth, and has converted it to practice, he observed, the care of a patient will be most delicate, most compassionate, most elevating, and most competent. Nothing is too good in research and specialization for the patient in such a hospital. "Our Heritage in Education" was the subject of an address by Doctor J. T. Leddy, Dean of Arts and Science, University of Saskatchewan, Saskatoon. Doctor O. C. Trainor spoke on "The Value of Organization".

The day's program closed with Benediction in St. Paul's Cathedral.

Officers

President: Sister M. Laurentia, Providence Hospital, Moose Jaw

Vice-president: Sister Philippe de Cesaree, Notre Dame Hospital, North Battleford

Secretary-treasurer: Sister M. Edmund, Providence Hospital, Moose Jaw

Councillors: Sister A. Keohane, St. Therese Hospital, Tisdale; Sister B. Bezaire, St. Paul's Hospital, Saskatoon; Sister M. Anacleta, St. Joseph's Hospital, Estevan; and Sister M. Elizabeth, St. Peter's Hospital, Melville. ●

Common Complaints

Garden-cephalitis lethargica: seasonal malady making the male allergic to weeds and lawn-mowers.

Ashtigmatism: inability to see an ash tray, however large or prominently placed.

Status emphaticus: a condition in which the patient believes everyone else to be wrong.

Manner-allergy: the patient divests himself of his good manners along with overcoat when entering his own home.

Dishpepsia: a complaint which gives the patient such overwhelming self-satisfaction from giving his wife a hand with the dishes that he considers himself automatically absolved from any other jobs.

Gastro-energitis: patient appears to be in a coma until a meal is announced, whereupon he immediately leaps to his feet and rushes off to finish a half-done job. — *English Digest*

Cupboard doors and bureau drawers will slide easily and not stick or jamb if you rub the edges with paraffin wax or dry soap.

Coming Conventions

Nov. 30—Annual Meeting of the Canadian Society of Hospital Pharmacists, Queen Mary Veterans' Hospital, Montreal, P.Q.
Dec. 5-8—American College of Hospital Administrators, Fellows' Seminar, University of Michigan, Ann Arbor.
Dec. 8-12—Institute of Nursing Service Administration, Knickerbocker Hotel, Chicago, Ill.
Feb. 5-6—American Hospital Association, Midyear Conference, Drake Hotel, Chicago, Ill.
Feb. 10-13—American Protestant Hospital Association Convention, Palmer House, Chicago, Ill.
May 15-19—Biennial Meeting of the Canadian Hospital Council, Chateau Laurier, Ottawa.

With the Auxiliaries

(Continued from page 74)

women's auxiliary to the Portage la Prairie General Hospital, Portage la Prairie, Man. These included a rag drive during which 9,372 pounds of rags were collected and sent to the White Cross Guild in Winnipeg. The auxiliary received a cheque for $281 for this work. A tag day brought in a total of $418 and the hospital harvest brought contributions of vegetables and fruit for the hospital. Members voted $500 for the purchase of linens at a recent meeting. It was also decided that two ladies would visit the hospital monthly to see what is most needed.

* * * *

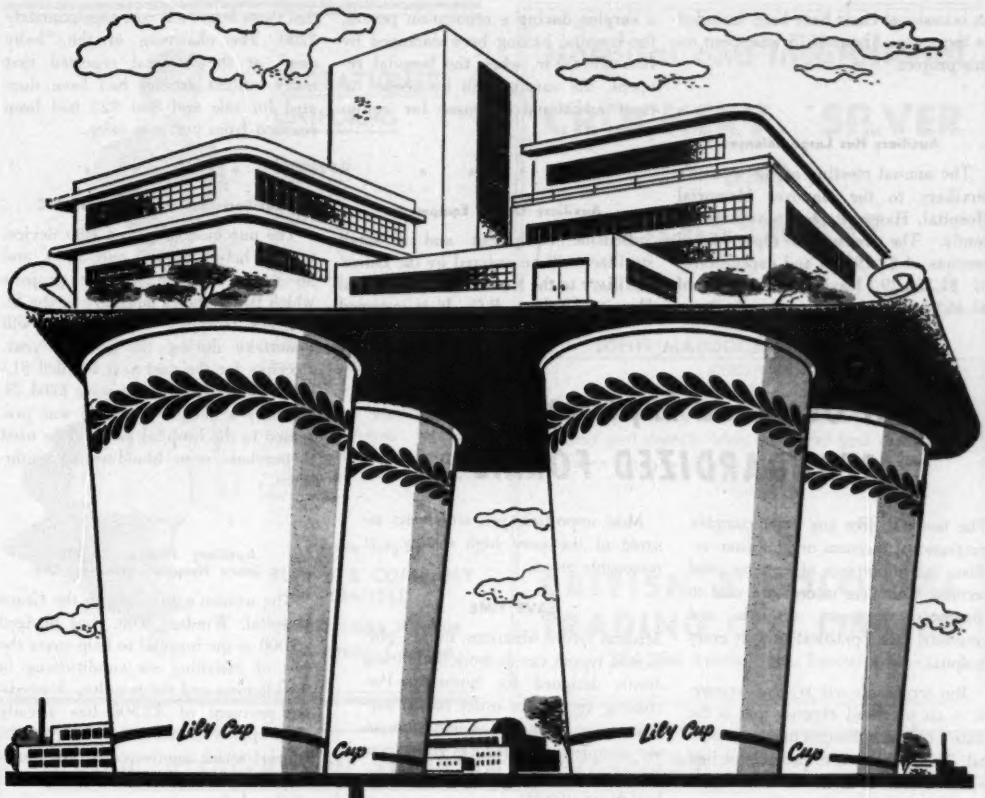
Annual Reports Heard by Auxiliary at Saskatoon, Sask.

Annual reports were heard by the women of the auxiliary to the St. Paul's Hospital, Saskatoon, Sask., at their recent annual meeting. Activities during the year included two teas, a membership tea, a rummage sale in the fall, and a spring tea at which aprons, home cooking, and candy were sold. On the two days preceding Mother's Day, auxiliary members sold flowers at the hospital. The auxiliary contributed to the Christmas Cheer Fund, purchased overbed tables, made the final payment on a resuscitator, and awarded a scholarship to one of the graduates of the 1952 nursing class, as well as presenting a medal to a member of the class.

* * * *

Private Room Furnished by Auxiliary at Wadena, Sask.

A private ward in the Wadena Union Hospital, Wadena, Sask., has been completely refurnished by the women's auxiliary. The ward, orginally known as the rose room, was furnished about 30 years ago by the auxiliary and, although there have been changes made in the room, it has not been completely refurnished since that time. A new adjustable bed, boudoir lamp, footstool, overbed table, dresser, easy chair, and



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an occasional chair have been included in the room. About $575 was spent on this project.

* * * *

Auxiliary Has Large Balance

The annual meeting of the women's auxiliary to the Hanover Memorial Hospital, Hanover, Ont., was held recently. The treasurer's report listed receipts of $2,796.23 and expenditures of $1,332.29, leaving a balance of $1,463.94. The auxiliary has built up a surplus during a renovation period, the hospital having been damaged by fire. However, when the hospital reopens, the surplus will be needed to meet additional expenses for equipment.

* * * *

Auxiliary Orders Equipment

Bedside equipment and a small sterilizer will be ordered by the ladies' auxiliary to the Kootenay Lake General Hospital, Nelson, B.C. It is expected that these items will cost approximately $200. The chairman of the "baby case" at the hospital reported that many knitted articles had been donated for sale and that $25 had been realized from previous sales.

* * * *

Auxiliary Active at Comox, B.C.

The purchase of a spot film device, to cost between $700 and $800, and an x-ray machine will be projects which the women's auxiliary to the St. Joseph's Hospital, Comox, B.C., will undertake during the coming year. Receipts for the past year totalled $1,062.28 and expenditures were $864.78. Recently a cheque for $175 was presented to the hospital and will be used to purchase some blood-testing equipment.

* * * *

Auxiliary Pledges $5,000 to Grace Hospital, Windsor, Ont.

The women's auxiliary to the Grace Hospital, Windsor, Ont., has pledged $5,000 to the hospital to help cover the cost of installing air conditioning in the kitchens and the laundry. Immediate payment of $2,500 has already been approved and proceeds from the concert series, sponsored by the auxiliary, will be applied to the remainder of the pledge.

* * * *

Oxygen Tent to be Donated to General Hospital, Saint John, N.B.

The women's auxiliary to the Saint John General Hospital, Saint John, N.B., have voted to purchase an oxygen tent for use in the hospital. A bequest of $500, which the auxiliary received recently, will be used to help cover the cost of the equipment.

* * * *

Auxiliary at Prince Rupert, B.C., to Publish Cook Book

The newest project undertaken by the ladies' auxiliary to the Prince Rupert General Hospital, Prince Rupert, B.C., is the compilation of a cook book made up of the ladies' prize recipes and tested by a qualified dietitian. Advertising space will be sold to local business firms to help cover the cost of publishing. At the first fall meeting, members were told that equipment valued at $389 had been donated to the hospital.

THE CANADIAN HOSPITAL

The Canadian Hospital is published monthly by the Canadian Hospital Council as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada, U.S.A., and Gt. Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscriptions for individuals directly associated with them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies, when available, are supplied at 50c each.

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Sask. Hospital Convention

(Concluded from page 48)

the importance of autonomy in all hospital affairs.

J. O. Probe, director, Saskatchewan Civil Defence, Regina, outlined civil defence plans for the province. He ruled out the likelihood of atom bomb attacks on the prairies but stressed the need for preparedness to render aid (with supplies and trained personnel) to the larger centres in the east and on the west coast.

Mrs. S. S. Alexander of Swift Current, president of the Saskatchewan Hospital Aids Association, reported on the many activities of her organization. Incidentally, she brought great credit on herself for reading a concise, well rounded report in the exact time allotted, a feat seldom accomplished.

Dr. A. L. Swanson, executive secretary of the Canadian Hospital Council, brought greetings from the council and discussed recent educational activities undertaken by the national organization.

In her paper "In-service Education", Lola Wilson, registrar, Saskatchewan Registered Nurses' Association, con-

cluded that this form of training pays large dividends in employee satisfaction, with resultant improvements in patient care, hospital rating, and in community public relations. Miss Wilson was heard again during the afternoon business session when she spoke out eloquently on behalf of the Saskatchewan Registered Nurses' Association's recommendation to the Saskatchewan Hospital Association asking for the adoption of improved salary schedules for nurses. The revised schedules were later accepted by the hospital association (see below).

Following a brief greeting from Colonel F. W. G. Miles of Regina, commissioner, Canadian Red Cross Society and a film on "Admission Chest X-rays" presented by Christian Smith of Regina, the business meeting concluded the sessions and officers were elected.

Officers

Past President: H. H. Bassett, Prince Albert.

President: H. B. Myers, Rosetown.

Vice-president and interim secretary-treasurer: John Smith, Yorkton.

Executive Members: Norman Hall, Shaunavon; S. N. Wynn, Yorkton; E. F. Bourassa, Regina; M. F. Kushnir, Canora; and Dr. H. E. Baird, Regina.—*A.L.S. and M.W.R.*

New Salary Schedules for Saskatchewan Registered Nurses

Recommendations for improved salary schedules for registered nurses, which were presented to the Saskatchewan Hospital Association, at their annual meeting, by the Saskatchewan Registered Nurses' Association, were adopted by the hospital association. The new schedule would increase the salary of nurses in general ward duty to $210 a month and would be scaled upwards to a minimum of $285 a month for supervisors in 36-bed hospitals. Recommended minimum salaries represent increases of $30 a month over present minimums. The increase represents a gross minimum; allowance for in-residence board and room (usually $30 a month) would be deducted.

It is recommended that a head nurse should receive a salary of not less than $225 and an instructor qualified by experience and special preparation should receive not less than $240. The salary recommended for a director of nursing is a minimum of $375.

(Concluded from page 76)

Provincial Notes

Unit, laboratories, nurses' quarters, kitchen, heating unit, and numerous storage rooms. Wards and the operating room are located on the main floor.

Saskatchewan

MOOSE JAW. A motion has been passed by the city council to go ahead with the construction of a new $1,200,000 hospital wing to the Moose Jaw General Hospital. It is expected that construction work will begin this coming spring.

* * * *

SASKATOON. Premier T. C. Douglas of Saskatchewan laid the cornerstone of the new University of Saskatchewan's $7,000,000 hospital at an impressive ceremony in September. The 550-bed institution is partially completed and is connected to the university's medical building which was completed two years ago. The hospital building forms a "T" with two wings at each of the three ends, making a central stem and six wings. The university's medical building is now a continuation of one of the wings. Being constructed by the provincial public works department, the major cost of the hospital is being met by the province with aid from the federal hospital construction grants. It is hoped that the hospital will be completed by September, 1954.

Alberta

CALGARY. It is expected that the east wing of Calgary's new $3,000,000 General Hospital will be ready for occupancy by the beginning of February. The south and west wings will probably be completed some seven months later.

* * * *

LETHBRIDGE. Major features of plans for the ground and sub-ground floors of the new municipal hospital were approved recently by the provisional hospital board. The sub-ground floor will consist of the following: radiology department, nurses' training school, storage, and out-patient clinics. Located on the ground floor will be the entrance and office, dining room and lounge, kitchen, laboratories, and emergency department. The board has also decided to make preparations for the extension of the dollar-a-day hospitalization scheme to the rural areas of the Lethbridge Municipal Hospital District on January 1, 1953.

ROCKY MOUNTAIN HOUSE. Alterations are being made in the Rocky Mountain House Municipal Hospital which will enlarge the administrative offices, provide space for a diet kitchen, increase the main kitchen, and make room for two dining rooms in the basement of the older building. The new east and north annexes are nearing completion.

British Columbia

PRINCE RUPERT. A contract has been let and work has begun on the largest item, a new boiler room and heating unit, in the Prince Rupert General Hospital's $95,000 modernization plans. The new installation will have two 50-horsepower boilers, with space for a third. Federal and provincial grants will help toward the cost of construction.

Notes About People

(Concluded from page 16)

Toronto, Ont., and afterwards became laboratory supervisor at the St. John's General. She was also the nursing arts instructor at that hospital and, until recently, was field consultant with the provincial public health nursing service.

* * *

• Miss Evelyn Wood, superintendent of the Chambers Memorial Hospital, Smiths Falls, Ont., has accepted the position of superintendent at the Ross Memorial Hospital, Lindsay, Ont. Miss Wood commenced her new duties on Oct. 1.

Blue Cross Plans to Meet in Montreal

A most important meeting of the Canadian Council of Blue Cross Plans will be held in Montreal from November 26th to 28th. At that time Plan directors and trustees will discuss policies concerning Blue Cross health care protection embracing eight provinces. The meeting will be divided into sections, namely: executive, November 25th; sub-committee chairmen with plan directors, Nov. 26th; plan directors, Nov. 27th; and plan directors with the trustees on Nov. 28th.

A man who does not smile should not run a shop.—*Chinese Proverb*

Stephens Memorial Award

(Suite de la page 42)

McGugan, vice-président du Conseil, au banquet annuel de la convention des Hôpitaux associés de l'Alberta. On lui offrait en même temps un petit cadeau personnel.

Ce Prix, dédié à la mémoire de feu le Docteur George Findlay Stephens, fut inauguré en 1949. Il est présenté pour service méritoire dans le domaine de l'administration des hôpitaux.

Quoique le Docteur Anderson se soit récemment retiré de l'administration active, il a depuis longtemps été un chef dans le domaine de l'hôpital. Né à Campbellford, Ontario, il étudia au Collège médical Trinity à Toronto, et gradua en 1902 du Collège médical de Manitoba. Le Docteur Anderson, passa plusieurs années dans le pratique, et devint l'un des premiers membres du personnel enseignant, lors de la formation de l'Ecole médicale de l'Université d'Alberta. En 1928, le Docteur Anderson fut nommé surintendent de l'hôpital Royal Alexandra à Edmonton, un post qu'il a detenu jusqu'a sa retraite vingt ans plus tard. Il devenait alors, en 1948, membre à vie des Hôpitaux associés de l'Alberta.

En plus d'avoir guidé son hôpital à travers les années difficiles des 1930, le Dr. Anderson a pris une part très active dans le développement d'organisations régionales et nationales. Il a été président de l'Académie de Médecine d'Alberta, de l'Association médicale d'Alberta et de l'Association des Hôpitaux de l'Alberta (devenue The Associated Hospitals of Alberta). Il fut le fondateur et président du Conseil d'administration de l'Hospitalisation de Groupe d'Edmonton (Edmonton Group Hospitalization Board). Membre actif du Conseil des Hôpitaux du Canada depuis plusieurs années, il en fut le vice-président en 1944-1945. Le Docteur Anderson a été un agrégé du Collège Américain des Administrateurs d'Hôpitaux depuis sa formation, et fut membre du Conseil des Régents de ce Collège pour le district 15. Il est aussi membre de l'Association des Hôpitaux des Etats-Unis.

En dépit de ses nombreuses occupations, le Dr. Anderson—que ses amis connaissent sous le sobriquet de "Andy",— a trouvé le temps d'être un joueur renommé du curling. Il est un membre à charte et fut président du Royal Curling Club d'Edmonton, ainsi que du Dominion Curling Association dont il est membre à vie. Il fut aussi vice-président du Royal Caledonian Curling Club of Scotland.

Vivement intéressé aux problèmes de l'éducation, le Docteur Anderson se soucia surtout de l'enseignement aux étudiants en médecine et aux infirmières. Plusieurs personnes renommées dans ces professions, comme dans le domaine de l'administration, sont fiers de le reconnaître comme précepteur.

On le respecte pour son bon jugement et on l'admire pour son dévouement inlassable, mais surtout, il est l'object d'une affection tout particulière de la part de ses amis et collègues.

Le Prix Comme Mémorial

Le Dr. George Findlay Stephens mourut en avril, 1948. De son vivant, il fut l'administrateur de deux des principaux hôpitaux du Canada — l'Hôpital Général de Winnipeg et l'Hôpital Royal Victoria de Montréal. On le considérait comme une des autorités les plus reconnues en administration

sour ce continent.

Parmi les honneurs qui lui furent accordés, on trouve l'Award of Merit de l'Association des Hôpitaux des Etats-Unis. Comme président de cette organisation, comme président du Conseil des Hôpitaux du Canada et dans plusieurs autres charges responsables, le Dr. Stephens a un record distingué.

On n'aurait pu choisir un témoignage plus approprié à la mémoire du Dr. Stephens, que de donner son nom à un prix méritoire Canadien tel que celui-ci. Ainsi chaque fois qu'on honore un Canadien exceptionnel, c'est le Dr. Stephens que l'on honore. Feu le Docteur A. K. Haywood de Vancouver fut de premier à recevoir ce prix; en 1950, il fut décerné à feu le Dr. Fred W. Routley de Toronto et en 1951 on le conféra au Dr. Lorne C. Gilday de Montréal.

Air-Pollution Study

A fact-finding study of the effects of air pollution on health over a long period of time is to be carried out in the area of Ontario around Windsor with the aid of a federal grant. The study results from complaints made to the International Joint Commission in 1949 and will be correlated with similar studies by the United States Public Health Services and the Detroit City Health Department in the Detroit area.

This is the first time such a comprehensive study has ever been undertaken. The first phase, expected to take about a year, will include an extensive review of existing health records in the area and also in another comparable district. The district chosen for comparative purposes is known as the "control area". Also within the first year a "pilot study" will be conducted to find out the best methods of measuring health factors or illnesses which are related to air pollution.

The second phase will probably be carried on for at least five years and will be a full-scale survey of sickness or health in the cities of Windsor and Detroit and the "control areas". Such a study will be possible through statistically-chosen groups representing high, medium, and low racial income groups in high and low pollution areas and low income racial groups occupying both poor and good housing. Consideration will also be given to such factors as nutrition, medical care, race, age, and family sanitation practice.

In its opening phase, the health study will require a supervisor, three enumerators working full-time, and several part-time research assistants. The cost, during the current fiscal year is estimated at $12,325.

Protection of Cotton Fabrics

Cotton is a heavy-duty fabric, able to withstand rigorous "tub 'em, scrub 'em" washing procedures, reports the American Institute of Laundering but the textile should not be immersed in too strong a chlorine bleach. This is especially true of embossed cotton prints treated with various resin finishes.

The institute's technicians explain that some resins used to hold embossed designs in the fabric absorb chlorine from the bleach, forming a new chemical compound. While the garment is being pressed, the compound breaks down releasing hydrochloric acid that eats the fabric.—*Institutions Magazine*

Notes on Federal Grants

(Concluded from page 78)

psychiatric social work. On his return, he will join the staff of the Manitoba School for Mental Defectives as a group worker with the boys in this school. The second award goes to a staff member of the Brandon mental hospital, who will take post-graduate training in psychology and psychometry at the University of Manitoba, preparatory to expanding services for mental testing at the hospital.

Public Health

The federal government has just earmarked $15,000 from its health grants to help set up a new rural health unit in the Minburn-Vermilion district of Alberta. Some 21,000 people, in an area of 3,384 square miles, will be served by the new unit. It will be staffed by a medical officer of health, two public health nurses, a sanitary inspector, a stenotechnician, and a part-time secretary-treasurer. The unit's main centre is to be Vermilion, with sub-offices at Innisfree and Kitscoty. It will be responsible for a general public health service, including organization of immunization programs, development of pre-natal and well-baby clinics, and inspection of milk, water, and food supplies to ensure their purity and safety. The federal grant meets 60 per cent of the cost of equipping and operating the new unit. The remaining 40 per cent is provided by the communities within the area.

Research

A federal grant has been awarded to the University of Western Ontario, London, to carry on a study of the relationship of vital statistics and population in western countries, particularly in Canada and the United States. It is now apparent that knowledge of a few basic indices such as the infant mortality or the crude mortality rates in an area gives an insight into a host of health and social conditions with only a very small margin of error. Information of this type will be useful to public health workers, sociologists, and statisticians concerned with the planning or administration of health and welfare programs.

The research is being carried out by Dr. Odin W. Anderson, associate professor in charge of the social aspects of medicine at the University of Western Ontario medical school, assisted by Mrs. Bernice Loeb. The federal grant toward completion of this study will be $1,080 in the current fiscal year.

Tuberculosis

A travelling clinic for the detection of tuberculosis in remote sections of Manitoba is again this year being supported by a federal health grant. First organized about two years ago, this service is designed to strengthen and extend the chest x-ray program in those parts of Manitoba not ordinarily reached by travelling clinics and where statistics show that deaths and illness from tuberculosis are higher than the average in other parts of the province.

Clinics have been held at such centres as St. Laurent, St. Lazare, Duck Bay, Vogar, Amaranth, Meadow Portage, Beaconia, Barrows, Kinisota, Ericksdale, Fairford, Camperville, Victoria Beach, Wabowden, Thicket Portage, Pikwitonei, Moose Lake, Ilford, Grand Rapids, Gillam, Cormorant Lake, and Churchill. In co-operation with the health units at Swan River and Steinback, regular clinics have been held in those centres.

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Nursing Staff Personnel Policies

(Continued from page 31)

tea, a freshly laundered uniform and, possibly, a room in the nurses' residence, with maid service. Further, hospitals have other compensating factors which we fail to interpret to our nurses and other employees. Not the least of these is security. We can assure those in our employ of continuous annual employment — we can guarantee them a pay cheque fifty-two weeks a year. Unions would give anything to be able to offer such assurance of security to every worker in industry. We know that many industrial workers pay dearly for their greater wage increases in lay-offs and in idleness due to strikes.

Hours of Work

Hours of work per day and per week should be definitely stated. There should be specific policy decisions on the length of the work day, the number of shifts, meal periods, rest periods, holidays, and vacations. The forty-four or forty-eight hour week is generally recommended for nurses and is rather generally adopted at the present time. Straight shifts are desirable. Hours on duty should be posted well in advance. Changes should be made in these only rarely, under pressing necessity, and only after consultation with the individuals concerned. Each nurse should expect her share of evening and night duty. Only under very unusual circumstances should a nurse be accepted who refuses to do other than day duty, as this creates a situation which is unfair to the other members of the staff who are left with more than their share of the least desirable shifts.

The length of annual vacations, and the conditions upon which paid vacations depend, should be clearly stated. Three weeks would seem a reasonable period, with extra time allowed after ten or more years of employment. Policies should also list the statutory holidays which the hospital observes and, as all nurses cannot be off duty the day on which the holiday falls, definite policies regarding compensating time should be specified to ensure uniform practice throughout the hospital. The conditions under which leave of absence will be granted and the maximum duration of such leave should be included.

Health and Safety

Regular health services should be a part of any personnel program since through them a great deal of preventable sickness may be eliminated. The nurse's physical condition has a decided influence on her attitudes and morale. Hospitals should be leaders in safeguarding the health of employees. In an adequate program each nurse receives a complete physical examination at time of employment and periodic examinations thereafter.

It is essential to have definite sick leave regulations, specifically stating the time allowed yearly, to what extent it is cumulative, and the conditions under which an employee becomes eligible for sick leave benefits. It is recommended that written application be required for sick leave benefits, supported by a medical certificate for a period of more than three or four days.

Hospitilization benefits, if any, should be clearly stated as well. Indications are that the trend is toward having the nurse pay for hospitalization, the cost of which can be handled

through a hospital care insurance plan. Hospitals should make membership in Blue Cross available to their staffs; some now make it a requirement for permanent staff.

Safety regulations should include requirements for the protection of patients, employees, and property.

Termination of Employment

Personnel policies should give specific details as to length of notice required for termination of employment and conditions under which the hospital may give such notice.

The terminal interview with all nurses leaving the hospital's employ is of great importance and value in determining the reasons for leaving and the causes of turnover. Through such interviews changes may be effected to correct existing unfavorable conditions. Naturally, one must be able to sift out bias and spite; however, when several nurses report the same reason for leaving, that reason should be investigated. Even when nurses are discharged or asked to leave, they should be interviewed in order to make sure that they know the reason for such action. This measure prevents bad public relations due to misinformation in the community. The objective in exit interview in such cases is to help the nurse as much as possible by pointing out the characteristics or inabilities which made it necessary to dismiss her, in this instance, and by suggesting how they can be corrected, with beneficial results in her next position. All nurses should be given an impartial hearing and made to feel that they are getting a square deal.

Retirement Pensions

If the hospital carries any kind of retirement security for the nursing personnel, the details of the plan, conditions for eligibility, and so on, should be written into the personnel policies. Results of several surveys all reveal that the most sought-after goal today is security — security not only in the present but also for the future. Pension plans produce tangible results in increased loyalty and effort which more than justify the cost. In addition, a pension plan makes it possible to retire older employees easily and to fill their positions with younger workers. This is also an incentive to the young to remain in the employ of the hospital since they know they may be promoted when an older employee retires. Many types of retirement pensions are

available today and it might be well for those of us who have not yet initiated such a plan in our hospitals to do some constructive thinking and planning in this respect. It is generally conceded at the present time that reasonable costs of maintaining a pension plan for employees should be recognized as a legitimate part of operating expense.

Good hospital personnel administration involves the development of the "team" spirit, the creation of a co-operative atmosphere in the hospital, where each individual — each nurse — receives satisfaction from the responsibilities laid upon her.

The finest of personnel policies, however, are of little value unless they are fully understood, consistently applied, and adhered to faithfully. Formulation of policies is only the beginning. Sympathetic interpretation can be made effective only by those supervisors who are in daily contact with the individual nurse. The supervisor directly represents management to the nurse. Supervision consists in the observation of personnel while they work, the inspection and evaluation of results in terms of good nursing and satisfied patients, and the guidance of those supervised, so that they may become more efficient. To accomplish this the supervisor must have a knowledge of hospital organization, must be familiar with the techniques of all duties required of those working under her, and, above all, must have skill in training and leading others. It is obvious, therefore, that the supervisor should be carefully chosen, should be equipped with adequate knowledge, and should receive proper training to fit her for the key position which she holds in the hospital organization. To my mind, this is one of the biggest problems which confronts hospitals today — the development of adequate training programs for supervisors. Undoubtedly, good supervision is one of the most important keys to good human relations in the hospital. I think it is safe to say that this is the level on which personnel stability is achieved or lost.

The task of developing and maintaining good personnel practices for staff nurses in hospitals is extensive and, in order to be effective, requires a real and continuing interest on the part of administration. A sound personnel program, however, will reward the effort made in its establishment by achieving more harmonious working relationships, decreased turnover, greater efficiency, and better public relations.

Tribute to Nurses

Professor Sir James Learmonth, giving the Lister Oration at the Royal College of Surgeons in London, and wishing to record his ever-increasing debt to the nursing profession, said: "Nursing is at once an art and a science. The existence of a highly trained and devoted body of women and men is inseparable from and indispensable to the practice of modern surgery. In both ward and operating theatre it is never easy to draw a dividing line between surgical care and nursing care, nor is it desirable to attempt to do so for they are one.

"When on occasions formal treatments and remedies fail, it is possible for a patient to be nursed back to life and health."—*South African "Nursing Journal."*

Diabetics Convene

(Concluded from page 52)

should not indulge in excesses of exercise or its lack. He should be prepared to estimate the carbohydrate, fat and protein content of the food he eats and the amounts eaten; and, if available, he should carry an emergency ration in case a regular meal is not available when required. He should carry an identification card with instructions written in each of the languages of countries through which he plans to travel, so that help can be administered in case of an emergency. Preferably, he should not travel alone.

All these items were planned for by your representative who travelled further in going to the I.D.F. Congress than any other diabetic who attended. However, even these routine precautions were not always sufficient to prevent complications arising. What, for example, should a diabetic do when he unexpectedly develops sea sickness on the second day out from port? Or what course should be followed on debarkation day when breakfast is served two hours earlier than usual and lunch unexpectedly delayed two hours? What dietary policy should be followed on passing from one country having a high carbohydrate low fat food supply to one serving characteristically low carbohydrate, high fat dishes? These and other special problems were encountered and the solutions attempted were not always adequate for diabetes control. In brief, it was extremely difficult to control diabetes during periods of travel. On the other hand, control was relatively simple during the stationary intervals when some kind of routine could be set up. The one day required to return home from London by air proved far more suitable for the travelling diabetic than the nine days required to get there by train and boat.

Stable periods occurred in London, England, at the conference in Holland, at Heidelberg in Germany, and again in Devonshire in southern England. During these intervals there was an opportunity to contrast the ways of life of the resident people with those of Canada. In England, the Netherlands, and Germany, a much larger proportion of the young people get exercise by cycling than in Canada. In one European country we visited, the great majority of grey and white haired women we saw appeared to fit into a single nutritional pattern: they were somberly dressed and obese. It is of more than casual interest that the country in question currently has one of the largest diabetic associations in the world.

One Sunday during our stay in the Netherlands we paid a visit to the cities of Arnheim and Nijmegen, names familiar to Canadians as battle fields of the Second World War. We saw the famous Waal bridge at Nijmegen which the Germans tried, unsuccessfully, to demolish and heard several accounts of the battle. We visited the Canadian cemetry near Nijmegen and paid not only our personal respects but also those of the association to our fellow countrymen who are buried there. This visit also helped to bring home to me the great debts we owe those men who made it possible for us to live under a government of our own choosing.

Perhaps, too, we should think more seriously of the opportunities at our disposal to contribute to the welfare of those who will follow us, particularly those with diabetes. Collectively, we represent the first generation of diabetics to survive with the help of insulin and nutritional science. Uncounted numbers of humans in earlier generations of young diabetics have wasted away quickly with this condition, literally starving in the presence of plenty. Future generations of diabetics will profit immensely by the knowledge gained by medical scientists from our experiences. Let us make our generation stand out in history not only for this accident of probability but for our active co-operation with the medical profession in obtaining solutions to the outstanding problems of diabetes for all time to come.

Two-Year Plan Evaluated

(Concluded from page 56)

the average graduate of "control" schools, is at least as well prepared for bedside nursing and better prepared for tuberculosis and psychiatric nursing.

2. The unusual educational values of the school are: a weekly student load which enables instruction to be by assignment and class discussions; close integration of theory and practice; a better preparation for advanced training.

3. Clinical experience is sufficient in amount and in variety.

4. The value of psychiatric experience is so considerable that its absence from a nursing school program is regrettable.

5. When a school has complete control of students' time, nurses can be trained at least as well in two years as in three, and under better conditions, but the training must be paid for in money instead of in service. Some new source of revenue is the only solution.

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Alberta Hospitals Convene

(Concluded from page 88)

slavery, family and tribal feuds, and other abuses of society, have had to go.

On the final morning of the convention, in a thought-provoking address by Judge J. M. George, president of the Associated Hospitals of Manitoba, regional hospital plans in Manitoba were outlined and the resulting improvements in the efficiency of the provincial hospital organization were stressed. Judge George was followed to the rostrum by Dr. A. L. Swanson and Murray Ross of the Canadian Hospital Council who discussed the activities of the national organization in its efforts to further educational programs and the efficient operation of hospitals.

The educational sessions drew to a close with a symposium on civil defence presented by Dr. L. O. Bradley, Dr. L. M. Rogers, and Lois Kremer, Reg.N. They emphasized the need for continuing activity and readiness to serve and warned against complacency. Delegates were informed that there is now available in Alberta an active civil defence consultant service to assist in completing individual hospital disaster plans.

At the final business meeting several important resolutions were endorsed and officers for the coming year were elected.

Officers

President: Judge Nellie V. Buchanan, Q.C., Edmonton;

Vice-president: Dr. D. R. Easton, Edmonton;

Secretary-treasurer: L. R. Addicad, Edmonton;

Directors: Leonard Wilson, Drumheller (immediate past-president); H. P. Wright, Calgary; W. Chesser, Lacombe; Sister M. Helen, Bertrand; and S. V. Price, Calgary. — *ALS, and MWR.*

Treatment Reduces Mildew

When a painted surface becomes mildewed, as much of the mildew as possible should be scraped off, then the surface washed thoroughly with a solution of a mild alkali, such as trisodium phosphate—about 2 oz. in 1 gal. of water. After the surface is rinsed carefully with clean water, it should dry for a day or two. Then a new coat of paint containing a special mildew-resistant compound should be applied to the surface.—*Institution Magazine*

WANT ADVERTISEMENTS

Administrator Wanted

Administrator wanted immediately for 204-bed Children's Hospital, Halifax. Apply stating experience, qualifications, and salary expected, to D. G. Grant, Robie Street, Halifax, N.S.

Dietitian Wanted

For modern 82 bed hospital. No training school. Salary $250.00 to $280.00 per month. Apply stating qualifications and experience to Superintendent, Canora Union Hospital, Canora, Saskatchewan.

Superintendent of Nurses Wanted

For fully modern 82 bed hospital. No training school. Salary $225.00 to $250.00 per month. Apply enclosing references, and stating qualifications and experience to Superintendent, Canora Union Hospital, Canora, Sask.

Dietitian Wanted

For 225-bed hospital. Primarily interested in therapeutic diets and teaching. Salary according to experience and qualifications. Apply to Superintendent, Ottawa General Hospital, Ottawa, Ont.

Dietitian Wanted

To take full charge in 100-bed hospital. Wide experience in hospital work essential. Good salary paid. Some knowledge of French a help. Reply Box 1134, The Canadian Hospital, 57 Bloor Street W., Toronto 5, Ont.

Registered Medical Records Librarian

McKellar General Hospital, Fort William, Ontario, requires the services of an Assistant Librarian. Entering into new Hospital of 135 beds. Excellent working conditions and remuneration. Apply to Superintendent.

Registered Nurses Wanted

Registered nurses for 74 bed general hospital: 44 hour week; rotating shifts; 1 month vacation per year. Gross salary $200.00 plus laundering of uniform; $5.00 increase after 3 months, 9 months, 21 months later. Residence accommodation available at hospital $15.00 per month. Meals available at hospital 50c per meal. Apply in phone or letter to Superintendent of Nurses, General Hospital, Portage la Prairie, Man.

Radiologist

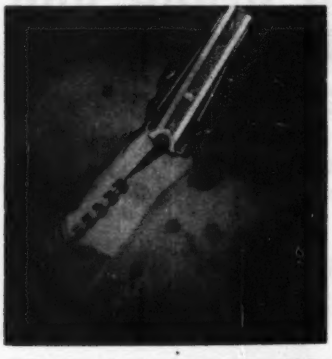
To head department in a 200-bed hospital with expansion program. Apply, stating qualifications, et cetera, to administrator, Belleville General Hospital, Belleville, Ont.

. . . Across the Desk

Clay-Adams Autoclip Applier

The Totco Autoclip Applier, a new automatic wound clip applier that gives greater efficiency and speed to wound closure, is now available from Clay-Adams Company, Inc., 141 East 25th Street, New York 10, N.Y. Its only limitations in operation are the surgeon's speed and skill.

Based on the standard Michel technique, the Autoclip Applier is fast and positive. Autoclips are automatically fed by the Applier in a fraction of the time required for applying individual clips—they are applied to the skin as rapidly as the surgeon can proximate the edges of the wound. Thus the surgeon can concentrate on actual closure of the wound and cosmetic results are better. Autoclips can be applied without nursing assistance.

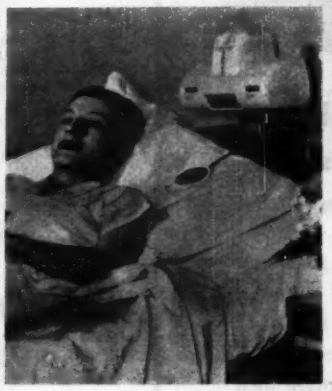


The Autoclip Applier can be widely used in hospitals for surgery and emergency work; by general practitioners and surgeons for office and outside emergency work; by industrial clinics, ship's medical departments, emergency clinics; in first aid kits.

The Autoclip Applier is completely described in Form 531, available from Clay-Adams.

Pillow Radios at Oakville-Trafalgar

The Oakville-Trafalgar Memorial Hospital, Oakville, Ont., is one of the first hospitals in Ontario to be equipped with personal pillow-radios. They are rented to patients on an hourly basis, and have proved a great help



in keeping the patients happy and amused.

* * *

Booklet on Power Scrubbing

Much interesting and practical information is contained in a booklet on power scrubbing equipment made available to hospitals by Dustbane Associated Companies, Ottawa.

Comparative surveys carried out indicate that at a labour cost of $1.00 an hour, the cost of mopping 1,000 feet of floor space daily for 1 year would be $300.00. It is claimed that the cost of scrubbing the same space per year with one of their 418P machines and the same janitor at $1.00 an hour would cost $100.00 per year. These costs would vary depending on the rate paid to the janitorial staff and the efficiency of the employee, but based on an over-all survey, there is a saving of $200.00 per year for every 1,000 square feet of area to be cleaned.

A copy of the booklet may be obtained by writing to any one of the Dustbane offices.

* * *

Gumpert Appointment

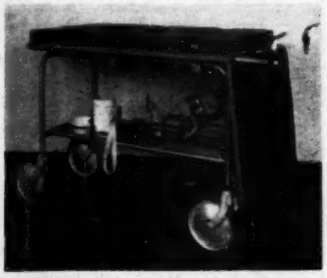
S. Gumpert Co. of Canada Limited, Toronto, announce the appointment of Mr. Hugh MacKenzie as sales representative to cover the Province of

Manitoba. Mr. MacKenzie was associated with Purity Flour Mills Limited for twenty-four years, and is acquainted with the institutional trade.

* * *

New Hausted Portable Examining Table

An efficient Portable Examining and O.B. Table, available with either stirrups, knee crutches or leg holders. This unit makes it possible for the patient to



be examined in any room and then in five seconds the breaking portion of the table can be lifted to a horizontal position and the complete top can easily be pushed back converting the

(Concluded on page 122)

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ELASTIC ADHESIVE BANDAGE
with the NON FRAY EDGE

Each strip of Bandage Fabric is woven separately with individual control of thread tensions.

The improved Non Fray Edge provides the Advantage of a Bandage which will lie flat on the Limb.

By reason of the Greater Softness of Doubled Thread, the Flexoplast Fabric is more impermeable to the Adhesive spread, is cleaner on the back and softer and more flexible in use.

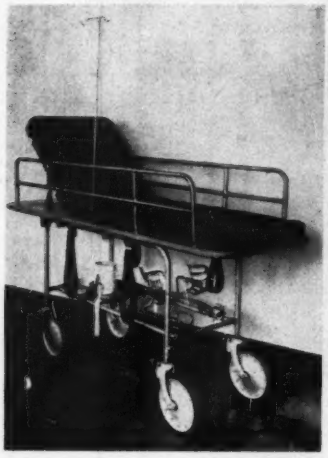
THE Stevens COMPANIES

TORONTO WINNIPEG CALGARY VANCOUVER

Across the Desk

(Concluded from page 120)

examining table to a most complete wheel stretcher, which has many useful accessories. It has the power Trendelenburg lift, shoulder braces, safety



side rails, restraining straps, Fowler attachment, intravenous standard, arm rest and oxygen tank holder. All these accessories are stored on the stretcher ready for use when needed.

The Hausted Portable Examining Table comes in two models, the standard and the deluxe, with height adjustment from 31″ to 38″. The standard model can be adjusted in height so the litter top will just clear the mattress and extend over the bed three and three-fourth inches, eliminating the hazard of the patient falling between the stretcher and the bed. With the deluxe model, by turning a crank the stretcher top will slide ten and a half inches over the bed and tilt making it possible for one small nurse to transfer the heaviest patient from the stretcher to the bed. Both of these are available in silver lustre paint finish or stainless steel.

Full details supplied by writing to Hausted Manufacturing Company, Medina, Ohio.

* * *

Dahlberg Opens New Factory

The Dahlberg Company, manufacturers of Dahlberg Hospital Pillow Radios and Dahlberg Hearing Aids, has moved into its new factory in Golden Valley, a suburb of Minneapolis, Minn.

The factory is situated on nearly three acres of land in one of Minneapolis' most charming suburbs. Kenneth H. Dahlberg, President and founder of the company, explained the out-of-city move as giving the factory more "elbow room".

The Dahlberg hospital pillow radio is a special radio built for hospital use only. Instead of a loudspeaker, the Dahlberg radio has an under pillow speaker which permits one patient to hear the program of his choice without disturbing other patients. Over 1,026 hospitals now use and enjoy the Dahlberg service made available to them through a plan which costs the hospitals nothing, yet produces for the hospitals a steady monthly income and at the same time eliminates the noise, confusion and bother caused by loudspeaker radios.

As a result of the demand by patients, who have used the Dahlberg radio in hospitals, for a similar radio suitable for home use, the new Dahlberg clock bed radio featuring an under-pillow speaker has been announced.

Further particulars are available from The Dahlberg Co. of Canada Limited, 1360 Green Ave., Montreal.

* * *

B. P. Manufactures Vinyl Floor Tile

A vinyl resin and asbestos fibre flooring material of the type so popular in the U.S.A. is now being marketed for the first time in Canada by Building Products Limited.

B. P. Vinyl Flortile is made in 9″ x 9″ tiles ⅛″ thick. It is claimed to be impervious to grease and most acid and alkali solutions. As it can be laid directly over concrete, on or below grade, as well as on suspended floors, it is ideal for use with concrete slab floors as well as for basement rooms.

Further information can be obtained by writing P.O. Box 6063, Montreal.

* * *

New X-Ray Diffraction Unit

A complete, new x-ray diffraction unit, known as the XRD-4, designed for film techniques only, is now ready for distribution in Canada by the General Electric X-Ray Corp. Ltd., Vancouver, Winnipeg, Toronto, Montreal.

Requiring about half the floor space taken by the all-purpose unit, the XRD-4, the new apparatus provides an x-ray source for all x-ray diffraction film techniques.

Full particulars may be obtained by writing to any office of the General Electric X-Ray Corporation Limited.

* * *

American Sterilizer's New Operating Table

American Sterilizer Company's new 1080 operating table resulted from years of consultation with leading surgeons, anaesthetists and operating room supervisors. The 1080 table anticipates every basic posturing posi-

tion that modern surgery demands. It is claimed that it is unique in its ease of control within a height range of 27 inches through 45 inches — the short surgeon can now operate without resort to footstool.

It is completely head-end controlled. On the left, for Trendelenburg with Geared Indicator Dial, only 20 turns of crank-handle provide 45° of Trendelenburg, or reverse Trendelenburg. On the right, the crank-handle used in conjunction with the position selector lever articulates table top to selected position of foot, flex, side and back, eliminating trial and error during operation even though table movements are obscured by drape sheets. Bulletin C-107 is available on request.

25 Minute Sound Slide Series Available

This new visual aid to the surgical team is available for scheduled showings. It illustrates the responsiveness of American's New 1080 Table to all positioning techniques.

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